VS A15 (4) 15M 10/57 08328

8348 CERTIFICATE OF DEATH

|      |       | ## | 0  | J | 4 |
|------|-------|----|----|---|---|
| Rea. | Dist. | Ne | ٥. |   |   |

| 1. PLACE OF DEATH<br>o. COUNTY                                       | St. Ma  | ry's                               | MAR                               | (LAND 2. US                  | STATE Maryla                                       | L.                               | COUNTY                      |  | odmissian)                                    |
|--|---|------------------------------------|-----------------------------------|------------------------------|--|----------------------------------|-----------------------------|--|---|
| b. CITY OR TOWN (I<br>RURAL and give of<br>Leonard                   |   | ts, write c                        | LENGTH OF STAY                    | IN 16 c.                     | Colton!  | s Point                          | ls, write RURAL             | and give near  | est tawn)                                     |
|  | St. Mary  | ive street add                     | ospital                           | 10                           | STREET ADDRESS                                     |                                  |                             | •  | IS RESIDENCE<br>ON A FARM?<br>YES NO          |
| 3. NAME OF<br>DECEASED<br>(Type or print)                            | Fr  | ederi                              | Middle L.                         |                              | lost<br>Amann                                      | 4. DATE<br>OF<br>DEATH           | Month<br>July               | Day  | Year<br>19 59                                 |
| 5. SEX<br>Male   | 6. COLOR OR RACE  | 7. MARRIES                         |                                   | 10                           | e OF BIRTH   | 9. AGE                           | birthday) Mar               | The state of the s | F UNDER 24 HRS.<br>Hours Min.                 |
| Ouring mast of world   | king life, even if retired                                | dane 10b. Kii                      | ND OF BUSINESS O                  | OR INDUSTRY 1                | 1. BIRTHPUCE (State                                | 7.7                              |                             | 2. CITIZEN OF  | WHAT COUNTRY                                  |
| 13. FATHER'S NAME  | RIN U. S. ARMED FOR                                       | , A 777                            | 2 (2 77 77)<br>OCIAL SECURITY NO  |                              | Masy   | IAME ?                           | Address                     |  |   |
| 18. CAUSE OF DEA   | (If yes, give war or dates of s                           | 57                                 | 8-28-167<br>for (a), (b), and (c) | 4 Mary                       | Elizabet   | hAmann                           | 2 Coli                      |  | RVAL BETWEEN                                  |
| Canditions, if a gave rise to i couse (a), stating lying cause last. | mmediate the under-                                       | )<br>)<br>.)                       |                                   |                              |  |                                  |                             |  |   |
| TCATIC   | HER SIGNIFICANT CON                                       |                                    |                                   |                              |  |                                  |                             | N PART 1(a) 19   | PERFORMED?                                    |
|  | AS UNDERLYING []<br>G CAUSE OF DEATH<br>MEDICAL EXAMINER) | 206. DESCRI                        | IBE HOW INJURY C                  | CCURRED. (Ente               | er nature af injury in f                           | Part I or Part I) of it          | em 18.)                     |  |   |
| 20c. TIME OF INJUR<br>Have a. m.<br>p. m.                            | Y Month, Day, Ye  | ar 20d. INJU<br>While<br>at work [ | URY OCCURRED  Nat while of wark   | 20e: PEACE Of<br>factory, st | F INJURY (Home, farm,<br>treet, affice bldg., etc. | , 20f. (City or town.)           | וו                          | (County)   | (State)                                       |
| ACTUAL SIGNATURE OF  | at I attended the   | reen                               | well                              | death accu                   | Le   | TM from the ADDRESS (Street, cit | causes and y or town, state | an the date )  Dec(  | w the decease<br>e stated above<br>DATE SIGNE |
| 220. BURIAL, CREMATIC  |   | OF :                               | 22c. NAME OF CEM                  | ETERY OR CREA                |  | 22d LOCATION (C                  | ryland                      |  | (State)                                       |
| Purial  23. FUNERAL DIRECTOR   |   | 959                                | SACRED                            | HEART                        |  | BUSHWOOD BY REGISTRAR            | 24b. REGISTRAI              | R'S SIGNATURE  | MD.   |
| W. CLARKE  | MATTINGI  | EY. I                              | EONARDT                           | OWN. M                       | D. DATE 111  | (min                             |                             | 9 4  |   |

OF THE WILLIAM THE REST TO BEAUTY A SPORT AT SOME AND THE HIMAG TO STADEHING PACE Sold in the second bing terms and conformation of the contract of and a resulting and indigence of the property of

VS A1S (4) 15M 10/57

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08329

8349 **CERTIFICATE OF DEATH** 

| 1. PLACE OF DEATH 0. COUNTY                 | W                                    |                | MARYLAN                 | II.       | USUAL RESIDENCE       | -            | a h.             | If institution | n: Residence  | before adr    | mission)     |
|---|--------------------------------------|----------------|-------------------------|-----------|-----------------------|--------------|------------------|----------------|---------------|---------------|--------------|
| ST.   | Mary's                               | ha a salta d   |                         |           |                       | yland        | 1                |                |               | Mary          | -            |
| RURAL and give ne                           | orest lown)                          |                | LENGTH OF STAY IN       | ь         | c. CITY OR TOWN       |              | orporate limit   | s, write RU    | RAL ond giv   | re nearest to | own)         |
| Leonardt                                    |                                      |                | D.O.A.                  |           | Califor               |              |                  |                |               |               |              |
| OR INSTITUTION                              | AL (If not in hospital, g            |                |                         |           | d. STREET ADDRESS     | S            |                  |                |               |               | RESIDENCE    |
|   | St. Mary                             | r's Ho         | ospital                 |           |                       |              | ···              |                |               |               | NO D         |
| 3. NAME OF<br>DECEASED                      | Fir                                  | -              | Middle                  |           | Losi                  | 4. DA        |                  | Month          | )             | Doy           | Year         |
| (Type or print)                             | Oller                                |                | Denning                 |           | Barefoot              | DE           |                  | ly             | 1'            | 7.            | 19 59        |
| S. SEX                                      |                                      | 7. MARRIED     | NEVER MARRIED           |           | ATE OF BIRTH          |              | 9 AGE            |                |               |               | NDER 24 HRS. |
| Male  | White                                | WIDOWED        |                         |           | pt.20,18              |              | 00               | yrs.           | Months De     | ays Hou       | rs Min.      |
| 10a. USUAL OCCUPATIO                        | ON (Give kind of work a              | done 10b. Kit  | ND OF BUSINESS OR II    | NDUSTRY   | 11. BIRTHPLACE (SI    | ate or forei | gn country)      |                | 12. CITIZI    | EN OF WH      | AT COUNTRY   |
| Farmin                                      |                                      | <b>'</b>       |                         |           | North                 | Caro         | lina             |                | U. S          | S.A.          |              |
| 13. FATHER'S NAME                           |                                      |                |                         | 1.        | . MOTHER'S MAIDE      | N NAME       |                  |                |               |               |              |
|   | Westbro                              | ok Ba          | arefoot                 |           | Avey Ta               | art          |                  |                |               |               |              |
| 15. WAS DECEASED EVER                       | R IN U. S. ARMED FOR                 | CES? 16. SO    | CIAL SECURITY NO.       | 7. INFO   |                       |              |                  | Addre          | 55            |               |              |
| No  | ir yez, give nor or usine or v       |                | )-16-5137               | Mrs       | Ruth H.               | Bare         | foot             | Cal            | iforr         | nia,          | Md           |
| 18. CAUSE OF DEA                            | TH [Enter only one co                | use per line l | for (o), (b), and (c).] |           | 1                     | •            |                  |                | 1             | INTERVAL      | BETWEEN      |
| PART I. DEA                                 | TH WAS CAUSED BY: IMMEDIATE CAUSE (o | ("             | The Mark                |           | reclin                | MIN          | ^                |                |               | ONSET A       | ND DEATH     |
| 11201                                       | DUE TO                               |                | 1                       |           | 0                     |              |                  |                | - 5           | VENE          | ()           |
| Conditions, if or                           | en sublak Y                          | /W             | - 0111                  | 1         | · lena                | 110          |                  |                |               | 57            | 41           |
| gove rise to in                             | nmediate (                           |                | - null                  |           |                       |              |                  |                |               | 7 7           | The Car      |
| couse (o), stating t                        | ine under-                           |                |                         |           |                       |              |                  |                |               |               |              |
| Z PART II. OTH                              | ER SIGNIFICANT CON                   | -              | NTRIBUTING TO DEATH     | BUT NO    | RELATED TO THE TE     | RMINAL DIS   | FASE CONDI       | TION GIVE      | N IN PAPT 1   | tol 19 WA     | S ALITOPSY   |
| PART II. OTH                                |                                      |                |                         |           |                       |              | CHSL COTTE       |                | 1111111111111 | PER           | FORMED?      |
| 200. ACCIDENT WA                            | S UNDERLYING []                      | 20b. DESCRI    | BE HOW INJURY OCCU      | IRRED. (E | nter nature of injury | in Part Lar  | Part II of ites  | n 18 1         |               | 1153          | _ NO _       |
|   | CAUSE OF DEATH                       |                |                         | (-        | ,                     |              | 7 011 11 01 1101 |                |               |               |              |
| 20c. TIME OF INJURY<br>Hour o. m.           | Month, Day, Yes                      | or 20d. INJU   | DRY OCCURRED 20e        | . PLACE   | OF INJURY (Home, f    | orm, 20f.    | (City or town)   |                | (Cou          | intu)         | (Stote)      |
| Hour o.m.                                   | 19                                   | While          | Not while               | factory.  | street, office bldg., | etc.)        | , ,              |                | 1000          | ,,,,          | (Siore)      |
|   |                                      |                |                         | 10        | K/1                   | -            | 17 . 4           | (7)            |               |               |              |
| Y   | at I attended the                    | deceased       | 2                       | -4        | ., 1925, to_          | - Just       |                  |                |               |               | ne deceased  |
| alive on                                    | My 18                                | 1977           | , and that de           | ath oc    | curred of Z'          |              |                  |                |               | date sta      | ated above   |
| ACTUAL                                      | ,                                    | j              | Veh.                    |           |                       | ADDRES       | \$ (Street, city | or fown, st    | ale)          | /.            | DATE SIGNED  |
| SIGNATURE                                   |                                      |                | 113000                  | M.B.      |                       |              |                  |                |               | 1/1           | 3159         |
| PHYSICIAN'S                                 | D I                                  | . Bea          | M D                     |           | Gnor                  | + 1/4        | 110              | Manze          | Sand          | 1             | 1            |
| NAME (Type)                                 | P. J                                 |                |                         |           |                       | ZO PIL       | lls,             | nierr A        | Tanın         |               |              |
| 220. BURIAL, CREMATION<br>REMOVAL (Specify) | V. 226. DATE THEREO                  | F 2            | 2c. NAME OF CEMETER     |           |                       |              | CATION (CIT      |                | county)       | (5            | tote)        |
| Burial                                      | 17/21/59                             |                | Washingto               | on N      | ational               | Sui          | tland            | ,              | Mar           | ylar          | ıd           |
| 23. FUNERAL DIRECTOR'S                      |                                      | ** T           | ADDRESS                 | The s     | 24a. R                | EC'D BY RE   | GISTRAR 2        | 4b. REGIST     | RAR'S SIGN    | ATURE         |              |
| W. Clarke                                   | MACCINGTE                            | A reo          | nardtown,               | Md        | • DATE                | 101 2.0      | 1'59             | (1.1           | lun & to      | Gares         |              |

THE CHINICATE OF BEATH STATE OF STA the Park's all the minus COD ..... antique description Carlos Stell doctored . Stell and W.C. Intell Stell dening the state of the state o The second second of the second secon M

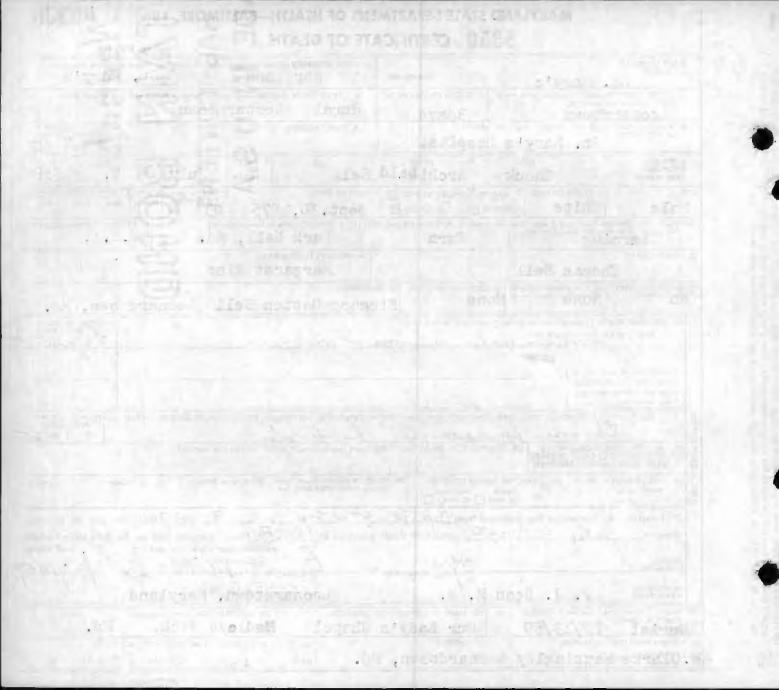
TO FUNERAL C

VS A15 (4) 15M 10/57

AN: The taw requires that the death certificate be executed wi

#### 8350 CERTIFICATE OF DEATH

| PLACE OF DEATH O. COUNTY St. Mary!s MARYLAND   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's   |
|--|--|
| b. CITY OR TOWN (If austide carporate limits, write RURAL and give nearest tawn)  Leonardtown  3days   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  XRural Leonardtown   |
| d. NAME OF HOSPITAL (IF not in hospital, give street address) OR INSTITUTION St. Mary's Hospital   | d. STREET ADDRESS  e. 15 RESIDENCE ON A FARM? YES NO   |
| 3. NAME OF DECEASED (Type or print) Enock Archibald  | Bell 4. DATE July 9, 1959  |
| S. SEX  6. COLOR OR RACE  7. MARRIED NEVER MARRIED    White   WIDOWED   DIVORCED   | 8. DATE OF BIRTH Sept. 30, 1875  9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Haurs Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired)  Farming  Farm   | Park Hall, Md. 12. CITIZEN OF WHAT COUNTRY?  |
| Thomas Bell  | Margaret Wise  |
| (Yan Po, or unknown)   (If M. august or dates of service)   To an  | eanor Gatton Bell Leonardtown, Md.   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gove rise to immediate cause (a), stating the under- lying cause lost.  Part ii. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY   |
| 206. ACCIDENT WAS UNDERLYING   206. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | PERFORMED? YES NO D. (Enter nature of injury in Part I or Part II of item 18.)   |
| 20c. TIME OF INJURY Manth, Doy. Year 20d. INJURY OCCURRED Hour o. m.  p. m. 19 While Nat while of wark at wark   | ACE OF INJURY (Home, farm, ctary, street, affice bidg., etc.) (City or tawn) (Caunty) (State)  |
| 21. I certify that I attended the deceased from Capail alive on 9, 1959, and that death ACTUAL SIGNATURE  PHYSICIAN'S P. J. Bean M. D.   | ADDRESS (Street), city or town, state)  ADDRESS (Street), city or town, state) |
| 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OF   |  |
| W.Clarke Mattingley Leonardtown, 1   | Md. DATE 1111 1 4 159 Orthur S. Kraus  |



|               |  | 835   | CERTIFICA                     | AIL OI L                                  | EASTILL                     |   | Reg. Dist.    | No.                              |               |
|---------------|--|---|-------------------------------|---|-----------------------------|---|---------------|----------------------------------|---------------|
| 1. 6          | PLACE OF DEATH   | t. Mary's   | MARYLAND                      | 2. USUAL RESID                            | ence (Where decedaryland    | sed lived. If instituti<br>b. COUNTY      |               | before odmission<br>lary s       | )             |
| t             | Leonard  | (If outside corporate limits, wr<br>nearest town)<br>COVII          | 10 hrs.                       | × Calla                                   | OWN (If autside cor<br>LWAY | porate limits, write f                    | URAL ond give | nearest town)                    |               |
| 4             | OR INSTITUTION   | St. Mary's I  |                               | d. STREET A                               | DDRESS                      |   |               | e. IS RESIDE<br>ON A FA<br>YES X | ARM?          |
|               | NAME OF<br>DECEASED<br>(Type or print)                             | ary kaby  | Ellensixi                     | Dykes                                     | 0.5                         | н July                                    | 18,           | Day Yea                          | 20            |
| 5. 5          | SEX  | 6. COLOR OR RACE 7. A   | AARRIED NEVER MARRIED         | B. DATE OF BIRTH                          |                             | 9. AGE (In years<br>lost birthdoy)        | Months Do     | EAR IF UNDER 2                   | 24 HRS        |
|               | emale  |   | OWED DIVORCED                 | July                                      | 17,1959                     | yrs.                                      |               | 10                               |               |
| 10a           | during most of wo  | ION (Give kind of work done<br>rking life, even if retired)         | 106. KIND OF BUSINESS OR INDU |   | ACE (State or foreign       | country)                                  |               | S.A.                             | JNTRY         |
| 13.           | FATHER'S NAME  | 9   |                               |   | MAIDEN NAME                 |   |               |                                  |               |
|               | NAME OF STREET   | £   |                               |   | mey Dyke                    |   |               |                                  |               |
| 15.<br>[Yes   | was deceased ev  | ER IN U. S. ARMED FORCES?<br>(If yes, give war ar dates of service) | 16. SOCIAL SECURITY NO.       | Mother                                    |                             | Add                                       | ress          |                                  |               |
|               |  | immediate DUE TO  | Conchar a                     | vell                                      |                             |   |               | INTERVAL SETWO                   |               |
| CERTIFICATION | PART II. OT  | THER SIGNIFICANT CONDITIO   | NS CONTRIBUTING TO DEATH BUT  | NOT RELATED TO                            | THE TERMINAL DISE           | ASE CONDITION GP                          | VEN IN PART 1 | PERFORM                          | TOPSY<br>MED? |
|               | 20g. ACCIDENT W<br>OR CONTRIBUTING<br>(IF EITHER, NOTIF)           | AS UNDERLYING 20b. G CAUSE OF DEATH Y MEDICAL EXAMINER)             | DESCRIBE HOW INJURY OCCURRE   | D. (Enter nature o                        | injury in Port 1 or P       | ort II of item 18.)                       |               |                                  |               |
| MEDICAL       | 20c. TIME OF INJU<br>Hour o.m.<br>p.m.                             | w w   |                               | ACE OF INJURY (I<br>ctory, street, office |                             | ity or town)                              | (Cou          | nty)                             | (Stote        |
|               | 21. I certify to alive an ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) | P.J. Bean   | ABen                          | M.D                                       |                             | n the causes ar<br>(Street, city or town, | nd an the a   | saw the declare stated a         |               |
| -             | BURIAL, CREMATION REMOVAL (Specify                                 |   | St. Aloysi                    |   |                             | ATION (City, lown,<br>nardtown            |               | VId. (Stote)                     |               |
|               | FUNERAL DIRECTOR   |   | Leonardtown, N                | Id.                                       | 24g. REC'D BY REG           |   | STRAR'S SIGN  |                                  |               |

TO HOSPITAL OR ATTENDING PIK VAN: The law requires that the death certificate be executed with may be retained by the hospital superading physician.

TO FUNERAL COOR: After this certificate has been signed by the attending physician and campletely page 3 shaural be detached for use as the burial-transit permit. Then please remove carbon papers. Pethe registrar priar to burial, cremation, the removal, and in any event within 72 haurs effect, death. VS A1S (4) 15M 9/5B

24 haurs after death. Page 4

funeral directar, WE Tiled with

ly filled in Pages I an

m 350万47人新的元 1. Particle of the state of the st E = E de Constitution and The state of the s Hard and the second of the sec

VS A15 (4) 15M 9/S5

K

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8352 CERTIFICATE OF DEATH 08333

|  |  |                              |                         |         |   |                        | IR.                                      | leg, Dist, P  | No.         |                    |
|--|--|------------------------------|-------------------------|---------|---|------------------------|--|---------------|-------------|--------------------|
| 1. PLACE OF DEATH                                    |  |                              |                         | 2.      | USUAL RESIDENCE (WI                               | here deceased          |  |               | efore admis | sion)              |
|  | St. Marys  |                              | MARYLAND                |         | Mary]   | Land                   | b. COUNTY                                | St. Ma        | arys        | 100                |
| b. CITY OR TOWN<br>RURAL and give                    | (If outside corporate limits,  | write                        | e. LENGTH OF STAY IN 16 |         | c. CITY OR TOWN (IF                               | outside corpor         | ote limits, write RUR                    | AL ond give   | negrest low | n)                 |
|  | nardtown   |                              |                         | 1       | Calif   | fornia                 | 1  |               |             |                    |
|  | PITAL (If not in hospital, give  | street or                    | ddress)                 |         | d. STREET ADDRESS                                 |                        |  |               | a. IS RE    | SIDENCE<br>A FARM? |
|  | St. Marys  | Hosi                         | oital                   |         | Rure  | al                     |  |               | YES         | NOX                |
| 3. NAME OF<br>DECEASED<br>(Type or print)            | RUTH   |                              | GOLD                    | FE:     | IMSTER  | 4. DATE<br>OF<br>DEATH | JULY                                     | 1             | Day         | Yeor<br>19 59      |
| S. SEX   | 6. COLOR OR RACE 7.  | MARRIE                       | ED NEVER MARRIED        | 8. D    | ATE OF BIRTH                                      |                        |  | UNDER 1 YE    |             | -                  |
| female   | white w  | IDOWED                       | DIVORCED [              |         | 1-3-1904  |                        | 55 yrs.                                  | Months Doy    | Hours       | Min.               |
| 10a. USUAL OCCUPAT                                   | TION (Give kind of work don orking life, even if retired)                  | e 10b. K                     | IND OF BUSINESS OR IND  | USTRY   | 11. BIRTHPLACE (State                             | or foreign co          | untry)                                   | 12. CITIZEN   |             |                    |
| House  |  | ]                            | Domestic                |         | North (   | Caroli                 | na                                       |               | US          | 5A                 |
| 13. FATHER'S NAME                                    |  |                              |                         | 1       | 4. MOTHER'S MAIDEN I                              |                        |  |               |             |                    |
|  | Martim Gol   | đ                            |                         |         | France  | es Bla                 | anton                                    |               |             |                    |
| 15. WAS DECEASED E                                   | VER IN U. S. ARMED FORCES  |                              | OCIAL SECURITY NO. 17   | INFO    | RMANT   |                        | Address                                  |               |             |                    |
|  |  |                              | I                       | 168     | ter L. Fe:  | imster                 | - Cali                                   | forni         | a, Mo       | 1,                 |
|  | PEATH [Enter only one couse<br>BEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (6) | per line                     | for (o), (b), and (c).] | ta      | Colla   | bac                    | (Shoel                                   |               | NTERVAL B   |                    |
| 90 Conditions, if                                    |  | 1                            | Fracture                | _       | Rt. Enj   | þ                      | C  |               | 20          | Line               |
| gove rise to<br>couse (o), statin<br>tying cause for | immediate DUE TO   |                              | Long Sta                | ord     | mig Khen  | males                  | 1 A Alle.                                |               | 10          | 1400               |
| PART II. C   | OTHER SIGNIFICANT CONDIT   | IONS CO                      | ONTRIBUTING TO DEATH B  | UT NO   | T RELATED TO THE TERM                             | INAL DISEASE           | CONDITION GIVEN                          | I IN PART 1(a | PERF        | AUTOPSY<br>DRMED?  |
|  | WAS UNDERLYING 120<br>NG CAUSE OF DEATH<br>FY MEDICAL EXAMINER)            | b. DESCI                     | RIBE HOW INJURY OCCUR   | RED. (E | 12-1  | Port I or Port         | II of item 18.)                          |               |             |                    |
| 20c. TIME OF INJ                                     | n. (1 2 10-0   | 20d. IN.<br>While<br>of work | _ Not while _           |         | OF INJURY (Home, form, street, office bldg., etc. |                        | or town)                                 | (Coun         | יין אין     | (State)            |
|  | 40- 20- 27   |                              | 10                      | ~       | 14-6-MC   | 1                      | 1 650                                    | 0 21          | 11423       | 100                |
|  | that I attended the de   | ecease                       |                         |         | , 1927, to  | P                      |  | that I last   |             |                    |
| alive on   |  | , 12                         | and that dea            | th oc   | curred at 252                                     |                        | the causes and<br>set, city or town, sto |               |             | ed abov            |
| ACTUAL<br>SIGNATURE                                  | Watal  | his                          | e G                     | M.D     | Lexi  |                        | - 7.6                                    | d. 7          | /2/5        | 9                  |
| PHYSICIAN'S<br>NAME (Type)                           | Wm. H. Pa  | tri                          | ck, MD                  |         | Lexi  | ngton                  | Park, M                                  | d.            |             |                    |
| 220. SURIAL, CREMAT<br>REMOVAL (Speci<br>Burial      | 7/5/59   |                              | Mt. Oliv                |         | REMATORY  |                        | lby, Nor                                 | th Ca         | roli        |                    |
| 23. FUNERAL DIRECTO                                  | OR'S SIGNATURE   |                              | ADDRESS /               | ×       |   | D BY REGISTI           | 400                                      |               |             |                    |
| PRR  | Cohingon T   | .000                         | andtam M                | a       | 0.175   | 1111 1 4 1             | 59 Can                                   | thun S. 1     | Times       |                    |

15 11 the same of the sa and forms of the second stay of The second of th

VS A15 (4) 15M 10/57

|    | 1te 835  | 3 CERTIFICA                                 | ATE OF DEATH  | 1  | Reg. Dist. No.  |
|----|--|---|---|--|---|
|    | 1. PLACE OF DEATH COUNTY St. Mary's  | MARYLAND                                    | 2. USUAL RESIDENCE (Who STATE Maryla                        | ere deceased lived. If institution b. COUNTY             |   |
|    | b. CITY OR TOWN (If autside carporate limits, write FURAL and give gaprest town)  Leonar atown                 | c. LENGTH OF STAY IN 16                     | c. CITY OR TOWN (If o                                       | utside carporate limits, write RUI                       |   |
| 1  | d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION St. Mary's                                 |   | d. STREET ADDRESS   |  | e. IS RESIDENCE<br>ON A FARM?<br>YES NO KJX             |
|    | 3 NAME OF First Cheryl Cheryl  | Ann   | Hall  | 4. DATE Month OF DEATH JULY                              | Doy Year<br>2, 1959                                     |
|    | Female White widow   | ED DIVORCED                                 | April 15,   | 59 last birthday)  | FUNDER 1 YEAR IF UNDER 24 HRS                           |
|    | 10a. USUAL OCCUPATION (Give kind of work done 10b. during most of warking life, even if retired)               | KIND OF BUSINESS OR INDU<br>特殊教育教育教育教育      | Marylan   | ar fareign cauntry)<br>d                                 | 12 CITIZEN OF WHAT COUNTRY:                             |
| 1  | George L. Hall   |   |   |  |   |
|    | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. (Yes. 10- or unknown)  If yes, give war or dates of service)  |   | orge L, Hall  | RiverSpri  |   |
|    | 1B. CAUSE OF DEATH [Enter only one couse per li PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  ULTO  DUE TO | ne for (a). (b), and (c).)                  | α.  |  | INTERVAL BETWEEN ONSET AND DOTH                         |
|    | Canditions, if any, which gove rise to immediate cause (a), stating the <u>under</u> tying cause lost.         |   |   |  |   |
| à, | PART II OTHER SIGNIFICANT CONDITIONS   | CONTRIBUTING TO DEATH BUT                   | NOT RELATED TO THE TERMIN                                   | NAL DISEASE CONDITION GIVEN                              | IN PART I(a) IP. WAS AUTOPSY PERFORMED? YES NO NO       |
|    | U (IF EITHER, NOTIFY MEDICAL EXAMINER)   | CRIBE HOW INJURY OCCURRED                   | D. (Enler nature of injury in P                             | art I ar Port II af item 18.)                            |   |
|    | Hour a.m. While  | NJURY OCCURRED 20e. PL/ Not white k at work | ACE OF INJURY (Home, farm, fary, street, affice bldg, etc.) | 20f. (City or town)                                      | (County) (State)  |
|    | 21. I certify that I attended the deceas   | 0   | accurred of 2100  | M, from the causes on sporess (Street, city or town, str | that I last saw the deceased d on the date stated above |
|    | SIGNATURE COULT C.   | This was                                    | w.D   | laurd our  | Jul. 7/3/50   |
|    | 270- BURIAL CREMATION, 22b. DATE THEREOF   | 3111 M.D.                                   |   | rdtown, Mary   |   |
|    | REMOVAL (Specify)  Burial 7/4/59  23. FUNERAL DIRECTOR'S SIGNATURE   | Sacred He                                   | art   | Bushwood,  | MD.   |
|    | W.Clarke Mattingley L  |   |   | Dir 150  | ribur S. Kraus  |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06094



# FOR STATE HEALTH DEPT y delay is necessary, please be funeral director. Page e retain? for your files. he Stat TO DEPUTY MEDICAL EXAMINE 11: certificate should be executed within 21 hours after 11ct, 1/2-y delay is execute the partificate, writing conditional in penal in them 18. Give Pages 1, 2, and 3. Fe funeral 4 should is rewarded to the 1. Medical Examiner's Office along with form PM3. Page 5 may are retained to FuneRAL, ARECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Staff or its designated agent, prior to barial, cremation, or removal, and in any event within 72 hours after death.

YS. A15ME 5M 2157

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (18335) 8354 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.

|   |              | LACE OF DEATH                             |   |                  | -                                       | 2 USUAL RE                             | SIDENCE (Where                  | deceased in    | ved. Il institu           | tion Residence befo | ore odmission)            |
|---|--------------|---|---|------------------|---|--|---------------------------------|----------------|---------------------------|---------------------|---------------------------|
|   |              | S1  | Marys   |                  | MARYLAND                                | o STATE                                | Marvlan                         | ıd             | P COUNT                   | St. M               | arvs                      |
|   | Ь            | . CITY OR TOWN (If ond give negres) town) | outside corporate t mitt, write i                 | RURAL            | C LENGTH OF STAY IN 16                  | c CITY O                               | R TOWN (If ours                 | ide corporoli  | e limits, write           | RURAL and give no   | orest town)               |
|   | L            | exington                                  | Park  |                  |   | × ]                                    | exingt                          | on Pa          | ark                       |                     |                           |
| < |              |   | L OR INSTITUTION (IF                              | not in hospi     | tal, give street address)               | d STREET                               |                                 |                |                           |                     | n IS RESIDE VI E          |
|   |              |   | -   |                  |   |  | Rural                           |                |                           |                     | YES NO 🔀                  |
|   | 3. h         | VAME OF<br>DECEASED                       | First   |                  | Middle                                  | Los                                    |                                 | DATE           | Month                     | 1 Doy               | Yeor                      |
|   |              | Type or print)                            | Granvi  | lle              | Vernon                                  | Hall                                   |                                 |                | ıly                       | 20                  | 19 59                     |
|   | 5. 5         | EX  | 6. COLOR OR RACE                                  | MARRIED          | NEVER MARRIED                           | B. DATE OF BIRT                        | Н                               | 9 A            | GE (In years If birthday) | IF UNDER TYEAR      | -                         |
| ı |              | male                                      | colored   | WIDOWED          | DIVORCED [                              | May 18.                                | 1902                            |                | 57 yrs                    | Months Days         | Hours Min.                |
|   | 10a.         | USUAL OCCUPATIO                           | N (Give kind of work do<br>life, even if retired) | ne 10b Kit       | ND OF BUSINESS OR INDUS                 |  |                                 | preign countr  | y)                        | 12, CITIZEN OF      | WHAT COUNTRY?             |
| ı |              | Labor                                     |   | D                | omestic                                 | Vi                                     | rginia                          |                |                           | USA                 |                           |
|   | 13.          | FATHER'S NAME                             |   |                  |   | 14. MOTHER'S                           | MAIDEN NAME                     | -              |                           |                     | -                         |
|   |              |   | Henry Hal   | .1.              |   | Unl                                    | known                           |                |                           |                     |                           |
|   | 15.<br>(Yes, | WAS DECEASED EVE                          | R IN U.S. ARMED FOR                               | ES? 16. 50       | DCIAL SECURITY NO 17.                   | NFORMANT                               |                                 |                | Add 52                    | 213-13th            | St.N.W.                   |
|   |              | no  |   |                  | 19-16-3009_                             | Gra                                    | nville                          | G. Ha          | all                       | Washing             | ton, D.C                  |
|   | Ì            |   | H [Enter only one cause                           | per line fo      | r (o), (b), and (c).]                   |  | ,                               | -              |                           |                     | AL BETWEEN                |
|   | - {          | PART I DEAT                               | H WAS CAUSED BY-                                  | Con              | mente al                                | ciole                                  | nt                              |                |                           | 65                  | minust                    |
|   |              | 4-20,1                                    | DUE TO  | A                |   |  |                                 |                |                           |                     |                           |
|   |              | Canditions, if on                         |   | ( 2772           | marry dos                               |  |                                 |                |                           | 1                   | 1., .                     |
|   |              | gove rise to immed<br>(a), stating the u  |   |                  |   |  |                                 |                |                           |                     |                           |
| - |              | couse last.                               | (c)   |                  |   | //                                     |                                 |                |                           |                     |                           |
|   | ğ            | PART II, OTHI                             | ER SIGNIFICANT COND                               | TIONS CON        | TREUTING TO DEATH BUT                   | NOT RELATED TO                         | THE TERMINAL                    | DISEASE CO     | ND-TION GIV               | EN IN PART 1(0) 19  | WAS AUTOPSY<br>PERFORMED? |
|   | 3            |   |   |                  |   |  |                                 |                |                           | Y                   | ES NO P                   |
|   | 24           | PRIMARY   or CON                          | SE WAS<br>TRIBUTING []                            | DESCRIBE I       | HOW INJURY OCCURRED (                   | Enter noture of H                      | njury in Port Lor               | Part II of ite | ım 18 )                   |                     |                           |
|   |              | CAUSE OF DEATH.                           | ,   |                  |   |  |                                 |                |                           |                     | mar - concen              |
|   | MEDICAL      | 20c. TIME OF MICH                         | I' while -  | 20d. IN<br>White | JURY OCCURRED 20e PLA<br>Not white foot | CE OF INJURY (<br>lory, street, offici | Home, form, 126<br>bldg., etc.) | Of (City or to | ywn)                      | (County)            | (Stote)                   |
|   | ¥            | 9.3 p.m                                   | 1 19  |                  | of work                                 |  |                                 |                |                           |                     |                           |
|   | -            |   |   |                  | mains described abo                     |  | Autopsy                         | ], Inspe       | ctian,                    | Inquiry 🔲,          | and in my                 |
|   |              | opinion death i                           | esulted from: N                                   | atural ca        | iuses 🛂, Accident                       | , Suicid                               | e 🔲, Ham                        | ricide []      | , Undeter                 | rmined manner       | - 🔲                       |
|   |              | ACTUAL                                    |   |                  | A.                                      | CHIEF                                  |                                 |                |                           |                     | DATE SIGNED               |
|   |              | SIGNATURE                                 |   | /                | VI Res Car The                          | m.v.                                   | MEDICAL EXAMIN                  |                |                           | 7/21                | /50                       |
|   |              | EXAMINER'S I                              | P.J. Bean   | MD               |   |  | MEDICAL EXAM                    |                | _                         | 1/64                | 03                        |
|   | 220.         | BUPIAL CREMATION                          | N. 226 DATE THEREOF                               | - 2              | 2c NAME OF CEMETERY OF                  |  |                                 |                | (City, fown, c            | or county)          | (State)                   |
|   | F            | REMOVAL (Specify)                         | /23/59  |                  | First Bapt                              | ist Ce                                 |                                 | irfa           |                           |                     | ,                         |
|   |              | FUNERAL DIRECTOR'S                        | SIGNATURE   |                  | ADDRESS                                 |  | 240 REC'D BY                    | REGISTRAR      |                           | TRAR'S SIGNATURE    |                           |
|   |              | James C.                                  | Chinn -   | Arli             | ngton, Va.                              |  | DATE JUL 2                      | 2 8 '59        | an                        | Mus S. Kran         | 4                         |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



VS A15 (4) 1SM 10/S7

| ARYLAND | STATE | DEPARTMENT | ÓF  | HEALT | H-BALTIMORE, | 18 |
|---------|-------|------------|-----|-------|--------------|----|
|         | Team  | 7 Sections | 7/3 | 6 63  | as a         | 10 |

118337 8356 CERTIFICATE OF DEATH Reg. Dist. No.

| 1   | PLACE OF DEATH     COUNTY                    |   |                            | 2. USUAL RESI    | DENCE (Where decease     |                                 |   | ore admission)        | -        |
|-----|--|---|----------------------------|------------------|--------------------------|---------------------------------|---|-----------------------|----------|
| L   | St   | . Mary's  | HODODON                    | o STATE          | laryland                 | b. COUNTY                       | St. Ma                                  | rv's                  |          |
|     | b. CITY OR TOWN ( RURAL and give no          | If outside corporate limits, write  | c. LENGTH OF STAY IN 16    | c. CITY OR       | TOWN (If outside corp    | porote limits, write R          | URAL and give no                        | earest town)          | -        |
| Т   | Leonar                                       |   | 1 day                      | X Lex            | ington P                 | ark                             |   |                       |          |
| ľ   | d. NAME OF HOSPIT                            | FAL (If not in hospital, give street  | oddress)                   | d. STREET A      |                          |                                 |   | e. IS RESIDENCE       | _        |
|     |  | St. Mary's  |                            | 504              | Enterpri                 | se Rd.                          |   | ON A FARM? YES NO TO  | )        |
| 3   | I. NAME OF<br>DECEASED                       | First   | Middle                     | Los              | 4. DATE                  | Man                             | th D                                    | ay Yeor               | =        |
|     | (Type or print)                              | Joseph  | Elmer                      | Herber           | OF DEAT                  | July                            | 9.                                      | 19 59                 |          |
| 1   | S. SEX                                       | 6. COLOR OR RACE 7. MARI  | RIED 🖾 NEVER MARRIED 🔲     | 8. DATE OF SIRT  | Н                        | 9. AGE (In years lost birthday) |   | R IF UNDER 24 HRS     | 5        |
|     | Male   | White widow   |                            | Jan. 4,          | 1908                     | 51 yrs.                         | Months Doys                             | Hours Min             |          |
| ľ   | On. USUAL OCCUPATION during most of work     | ON (Give kind of work done 10b.<br>king life, even if retired)  |                            | STRY 11. BIRTHPI | I TECHE OTL              |                                 |   | OF WHAT COUNT         | RY       |
| L   | Manager                                      | 5&10 store H  | .S.King Co.                | D.0.             | MOLENX                   | arokine                         | 0.5                                     | 3.A.                  |          |
| יו  | 3. FATHER'S NAME                             | stelle Goodwi   | n (Mother)                 |                  | MAIDEN NAME              |                                 |   |                       |          |
|     | Heilenck                                     | larie Philitip  | Sk                         | Jose             | ph Spence                | er Herbe                        | rt (Fat                                 | her)                  |          |
|     | S. WAS DECEASED EVE<br>(Yes, no. or unknown) | R IN U. S. ARMED FORCES? 16.  |                            | NFORMANT         |                          | Add                             | ,                                       |                       | -        |
|     | Army   | W.W.2   | Jo                         | oseph S          | . Herber                 | t,father                        | ,437 M                                  | eadow Ro              | d.       |
|     | 18. CAUSE OF DEA                             | ATH [Enter only one couse per li  | ne for (o), (b), and (c).) |                  |                          | /                               | IN                                      | TERVAL SETWEEN        |          |
|     | PART I, DEA                                  | TH WAS CAUSED BY:  IMMEDIATE CAUSE (6)  | Cener brail                | 1                | entosol                  | rage.                           | OK                                      | ISET AND DEATH        | -16      |
|     | 1 3 3/x                                      | DUE TO  |                            |                  |                          |                                 |   | The party             | 0 10     |
| ı   | Conditions, if o                             | ny, which ) (b)   |                            |                  |                          |                                 |   |                       |          |
|     | gove rise to i                               | mmediate  |                            |                  |                          |                                 |   |                       |          |
| Т   | lying couse lost.                            | (c)   |                            |                  |                          |                                 |   |                       |          |
| 3   | PART IT OT                                   | HER SIGNIFICANT CONDITIONS  | CONTRIBUTING TO DEATH BUT  | NOT RELATED TO   | THE TERMINAL DISEA       | SE CONDITION GIV                | EN IN PART 1(0)                         | 19 WAS AUTOPSY        | _        |
|     | 3  |   |                            |                  |                          |                                 |   | PERFORMED? YES NO [[] | 1        |
| 100 | PART II OTI                                  | S UNDERLYING [] 20b. DES  | CRIBE HOW INJURY OCCURRED  | Enler noture o   | f injury in Part I or Pa | ort II of item 18 )             |   |                       | _        |
|     |  | MEDICAL EXAMINER)   |                            |                  |                          |                                 |   |                       |          |
| 1   | 20c. TIME OF INJUR                           |   |                            | ACE OF INJURY (  | Home, form, 20f. (Ci     | ty or town)                     | (County                                 | ) {Stote              | )        |
| 1   | p. m.  | 19 While of wor   | 1401 WILLIE                | ,                | ong, etc.)               |                                 |   |                       |          |
| ı   | 21. I certify th                             | at I attended the deceas  | ed from Jalas              | 5 . 1959         | 10 Jule,                 | 7 105                           | /that I last s                          | aw the deceas         | - local  |
| П   | alive an                                     | July 4 195  | 2.7., and that death       | V                | ,/                       | m the causes o                  |   |                       |          |
| L   |  | ( /-, ( ') /  | 7                          |                  |                          | Street, city or town,           |   | DATE SIGN             |          |
| ı   | ACTUAL                                       | Will rah  | 1. E. V/                   | M.D              | 1 N . Wil                | 1 (52) 17                       | Pol) /1                                 | id 17-00              | :(       |
|     | BUNCLES A AME                                | 1 11 11200  | 1. 10 %                    |                  | 1                        | f                               | · - · · · · · · · · · · · · · · · · · · | talament - up-        | -50/     |
| L   | PHYSICIAN'S<br>NAME (Type)                   | L 11 (1)  | 1 10/1 /1.                 | //)              |                          |                                 |   |                       |          |
| 3   | 20. BURIAL, CREMATIO                         | N, 226. DATE THEREOF  | 22c NAME OF CEMETERY OF    | R CREMATORY      | 22d LOC                  | ATION (City, town, o            | or county)                              | (Stole)               |          |
|     | REMOVAL (Specify)                            | 7/13/59   | Balto, Nat. Co             | em.              | Bal                      | timore.                         | Md.                                     |                       |          |
| 2   | har les H                                    | s signature<br>. Schimunek Fu   | ADDRESS Home               |                  | 240. REC'D BY REGIS      |                                 | STRAR'S SIGNATU                         | IRE                   | distant. |
| 130 | 1331 Breh                                    | A MO O DESCRIPTION TO THE OWNER OF THE OWNER | THE LAT HOUR               |                  | DATE JUL 1 3             | 59 C.                           | thus S. Fire                            | мА                    |          |



registrar within 72 hours

MUSHITAL: The law requires that the death certificate by

NSTRUCTIONS

director,

by the funeral

TO FUTURED BY FIRE TO THE law requires that the death cartificate is filed with the certificate has been executed by the attending physician and completely filted in death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M -

by may be retained by the hospital or attending physician.

ATTENO The bottom

N.

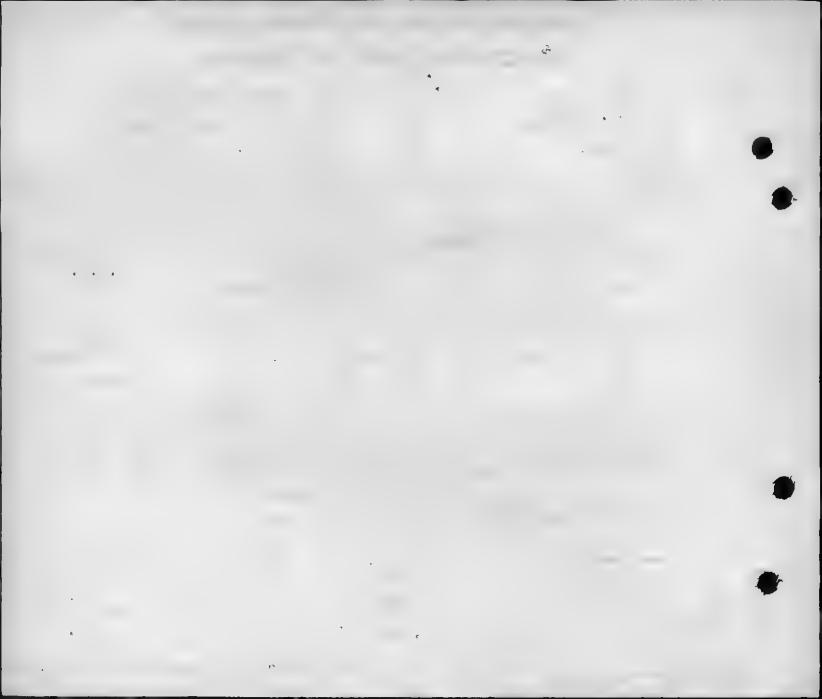
#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10642

#### 835 CERTIFICATE OF DEATH

|   | Reg. Dist. No  |
|---|--|
| 1. PLACE OF DEATH   | 2. USUAL RESIDENCE (HOME) OF DECEASED  |
| COUNTY St. Mary's MARYLAND  | STATE Md. COUNTY DT MARKS  |
| CITY (If outside corporate limits, write RURAL LENGTH OF STAY   | CITY (Il outsida corporeta limits, writa RURAL and give neerest town)  |
| OR and give neerest town) TOWN Morganiza  | X TOWN POLICE PRINT  |
| HOSPITAL OR   | STREET (If rural give location)  |
| INSTITUTION OR<br>STREET ADDRESS  | ADDRESS 440  |
| 3. NAME OF (First) (Middle)   | (Lest) 4. DATE (Month) (Day) Teer)   |
| DECEASED (Type or Print)  | OF T   |
| HOUR MARIN  | JORUNA TOUTE SUITE SUITE   |
| RACE WIDOWED, DIYORCED.   | OF BIRTH  9. AGE last birthdey   IFUNDER 1 YEAR   IF UNDER 24 HRS.   Months   Days   Hours   Months   Months   Days   Hours   Months   Months   Days   Hours   Months   Days   Hours   Months   Days   Months   Months   Days   Months   |
| M ColoRed (Specify) Single July   | 1959 DAM YOU   |
| 10e. VSUAL OCCUPATION (Give kind of work done during most of working life, even if OR INDUSTRY  | 11. B.RTHPLACE (State or foreign country)  12. CITIZEN OF WHAT   |
| ratired)  | Maryland U.Sountry?  |
| 13. FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME   |
| JEPENIAH J. JORDAN  | MAULINE E. BRISCOE   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL SECURITY NO.  | 17 INFORMANT & ADDRESS   |
| (Yes, no, or unk.) (If Yes, give wer or datas of sarvice)   | MOTHER   |
| 18. MEDICAL CI  | ERTIFICATION INTERVAL BETWEEN  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  | ONSET AND DEATH  |
| 7 a. IMMEDIATE CAUSE (A) Leaving 12   | result (scalarsher legeleft = Johnes   |
| ANTECEDENT CAUSE(S) DUE TO  |  |
| DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE  |  |
| STATING UNDERLYING CAUSE LAST. DUE TO   |  |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  | 4 ( ) ( )  |
| TO THE DEATH BUT NOT RELATED TO THE DISFASE OR CONDITION CAUSING DEATH,   | The (months)   |
| 19a, DATE OF OPERATION 19b, MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY?   |
|   | YES NO   |
| 21s. ACCIDENT WAS UNDERLYING 21b PLACE (Home, farm, factory, OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., atc.)   | 21c. WHERE DID INJURY OCCUR? (City or fown) (County) (Stata)   |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)  | L nor would be builded   |
| While Not while   | 21f. HOW DID INJURY OCCUR?   |
| M. at work et prork   |  |
| 22. I hereby certify that I attended the deceased from.   | 1961, to. 44. 20, 1954, that I last saw the deceased   |
| alive on, 19 19, and that death occurred  |  |
| SIGNATURE /   | ADDRESS (Streat, city, town, sete) DATE SIGNED   |
| 22 DUDIAL COSMANION LOAVE THE   | Musex Mulle 1912 1/2-1/39  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  | the state of the s |
| Burial 7/22/59 St. Geor   |  |
| 24. REC'D BY REGISTRAR'S SIGNATURE  OCT 1'59  C-tlan & Trans  | 2S. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   |
| DATE OF THE PARTY | W.Clarke Mattingley Leonardtown Md   |

78289 XU2



|   |   | I   |   |   |
|---|---|---|---|---|
| icessory, please exe-   | r. Page 4 should be   | •   | to burial, cremation,   | ( |
| frony delay is ne   | peral director  | your files.   | gistrof .   | ) |
| 4 hours ofter deoth. I  | ages 1, 2, and 3 to 1;  | ge 5 may be retained  | poges I and a with the reg                                      | ] |
| is certificate should be executed within 24 hours ofter depth. $H_{2}$ by delay is necessory, please exe- | "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to 1; peral director. Page 4 should be | The Chief Medico miner's Office along with farm PM3. Page 5 may be retained | OR: Page 3 shauld be used as a burial-transit permit. File page |   |
| is certificate shou   | "pending" in pe   | miner's Office ofo  | hauld be used as a bu   |   |
| EDICAL EXAMINE  | tificate, writing the   | the Chief Medico  | RECTOR: Poge 3 s  |   |

cute the ce forwarder TO FUNER. VS. A15ME(5) 5M 9/55

| Items 18820 FIMARYLAND STATE DEPARTA   | WENT OF HEALTH—BALTIMORE, 18 2'S CERTIFICATE OF DEATH Reg. Dist. No.   |
|--|--|
| PLACE OF DEATH   | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)  |
| C. COUNTY St. Mary's MARYLAN   | O STATE TO A THE STATE OF THE S |
| b. CITY OR TOWN III outside corporate limits, write BURAL C. LENGTH OF STAY IN   |  |
| and give nearest town)   | 2  |
| Patuxent River, USNAS   12 month   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Officer's Quarters   | d. STREET ADDRESS  o. 15 RESIDENCE ON A FARM?  |
|  | 11 Clayton Rd.   |
| 3. NAME OF First Middle DECEASED   | Lost 4. DATE Month Day Year  |
| (Type or print) Michael Gabriel  | KANE DEATH July 4, 1959  |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED   | - 1 lost bitthday  |
| Male Caucasian WIDOWED DIVORCED  | 28 November 1923 35 yrs. Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR IND during most of working life, even if retired)   | USTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?   |
| Aviator U.S. Navy  | New York USA   |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME   |
| George V. Kane   | Not obtainable   |
| 15, WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 112   | . INFORMANT Official U.S. Nawa Records.  |
| Yes 1-42 to 7-59 061-18-1513   | USNAS, Patuxent River, Maryland  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).   | INTERVAL RETWEEN   |
| PART I. DEATH WAS CAUSED BY: Coronary athe   | ONSET AND DEATH  |
| IMMEDIATE CAUSE (0) COTOTIALLY ACTIO   | Toscierosis  |
| 4 10.1 DUE TO  |  |
| Conditions, If any, which gave rise to immediate cause   |  |
| (c), stating the underlying DUE TO   |  |
| couse lost. (c)  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BE  20g. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING TO DESCRIBE HOW INJURY OCCURRED CAUSE OF DEATH.  Natural cause | IT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES X NO   |
|  | e. (Enter nature of injury in Part t or Part (1 of Item 18.)   |
|  | PLACE OF INJURY (Home, farm, 20f. (City or lawn) (County) (State) octory, street, office bldg., etc.)  |
| 21. I certify that I took charge of the remains described a  | bove, held an Autopsy 🛣, Inspection 🔀 Inquiry 🕅, and find that   |
|  | Suicide [], Homicide [], Undetermined cause .  |
| ACTUAL J. MILLER, LT MC USNR USNA  | S, Patux ent River, Maryland DAR SICHED  |

ASSISTANT MEDICAL EXAMINER EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER 220. BURIAL, CREMATION. 226. DATE THEREOF BURIAL (Specify) 7/9/59

22d. ŁOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY

Apponaug, Rhode Island 240. REC'D BY REGISTRAR

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Clarke Mattingley Leonardtown, Md.

DATE JUL 1 0 '59

arthur S. Krait



20

#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08339

PERFORMED? YES NO NO

(State)

**CERTIFICATE OF DEATH** 8359 Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. COUNTY a. STATE b. COUNTY MARYLAND St. Mary s Marvis CITY OR TOWN (If autside carporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn) RURAL and give nearest town) 4th Street Leonardtown days d. NAME OF HOSPITAL (If not in haspital, give street address) e. IS RESIDENCE ON A FARM? Lexington Park YES NO Mary's Hospital NAME OF 4. DATE Middle Manth Year DECEASED Dale Keffer Lee (Type or print) DEATH July 19 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED . B. DATE OF BIRTH Manths Male White WIDOWED | DIVORCED | July Yrs. 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Hansel O. Keffer Martha Jacquillard IS WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. INFORMANT Same Mather INTERVAL BETWEEN 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** 

Conditions, if any, which gave rise to immediate **DUE TO** cause (a), stating the underlying cause last. PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1101 19. WAS AUTOPSY 20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, 20e PLACE OF INJURY (Home, farm, Day, Year 20d. INJURY OCCURRED 20f. (City or town) factory, street, affice bldg., etc.) While Nat while at work 🔲 at wark p. m.

21. I certify that I attended the deceased fram hat death occurred at 1311MM, fram the causes and on the date stated above. alive an ACTUAL SIGNATURE

PHYSICIAN'S P.J. Bean M.D NAME (Type)

Great Mills. Md.

ADDRESS (Street, city or town, state)

22a. BURIAL, CREMATION, 22b DATE THEREOF 22d. LOCATION (City, tawn, or county) 22c. NAME OF CEMETERY OR CREMATORY (State) Bublak Specify Ebenezer Great Mills, Maryland 24b. REGISTRAR'S SIGNATURE

Clarke Mattingley Leonardtown, Md.

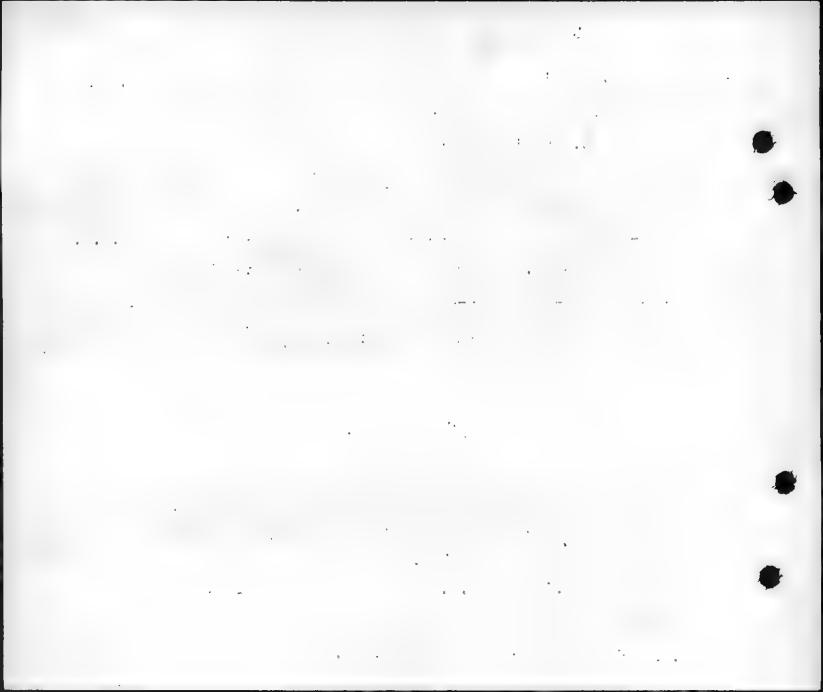
24g, REC'D BY REGISTRAR DATE 1111 2 0 '59

Orthon & Kraus

(Caunty)

Ethat I last saw the deceased

page 0 VS A15 (4) 1SM 9/SB



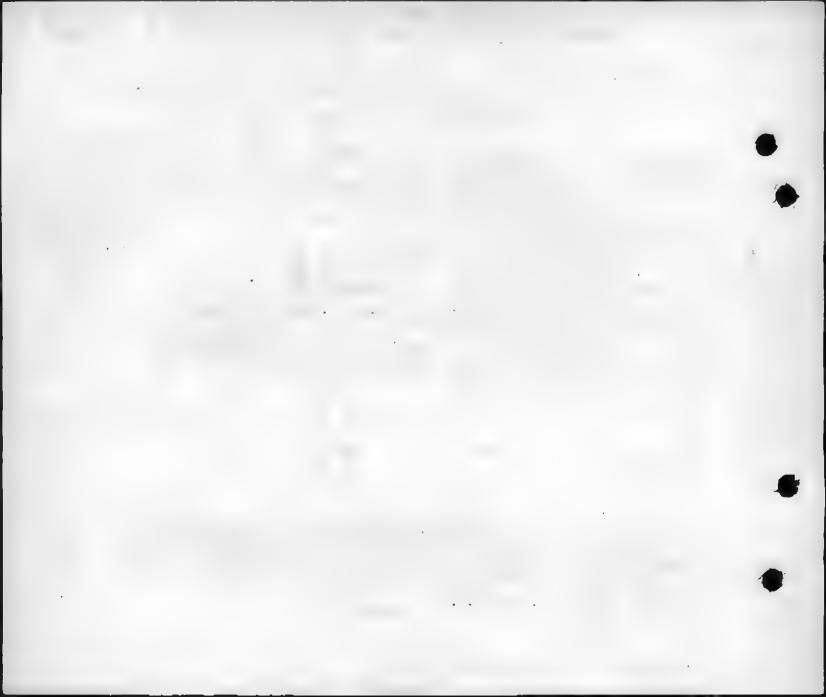
# death. If my delay is necessary please it and it is and

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8360 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(18341) Reg. Dist. No.

| o. COUNTY St. Mary's  | MARYLAND   | 2. USUAL RESIDENCE (Where deceased fived o. STATE O. 15 - 2007 - 2007   | b. COUNTY St. Mary's                     |
|---|--|---|--|
| b. CITY OR TOWN (It suiside corporate hmits, write RURA and give recres) (awn)              |  | c. CITY OR TOWN (If outside corporate li                                |  |
| Rural Abell   | Life   | X Rural Abell   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (IF not  |  | d STREET ADDRESS  | ON A FARM?  YES NOT                      |
| 3. NAME OF First DECEASED   | Middle   | Lost 4. DATE<br>OF  | Month Day Year                           |
| (Type or print) Joseph  | Francis 1  |   | ly 30, 1959                              |
| 5. SEX 6 COLOR OR RACE 7. N   | ARRIED NEVER MARRIED 3   | ATE OF BIRTH 9 AGE  | (In yours IF UNDER TYEAR IF UNDER 24 HRS |
| 110.30  | OWED DIVORCED  | 1909 50   | yrs Months Days Hours Min                |
| 19a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 106 KIND OF BUSINESS OR INDUSTI  | 11 BIRTHPLACE (State or foreign country)                                | 12 CITIZEN OF WHAT COUNTRY?              |
| Waterman, Farming   |  | Maryland  | U.S.A.                                   |
| 13. FATHER'S NAME   | Paragraph of Managraphy (Managraphy)   | 4. MOTHER'S MAIDEN NAME   |  |
| Legard Maddox   |  | Mary N. Woodl   | and                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?  [Yes, no, ar unknown]                         | 16 SOCIAL SECURITY NO. 17. IN  | DRMANT  | Address                                  |
| No  | 220-16-4748 Har  | old J. Maddox Kkg   | XX, Avente, Maryland                     |
| 18 CAUSE OF DEATH [Enter only one couse per   | all the second of the  |   | INTERVAL BETWEEN                         |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)   | ( Dr. Aci  | tio Beart land  | ONSET AND DEATH                          |
| 163X DUE TO   | - Congre   | - Jaco  | and the                                  |
| Canditions, if any, which)  | Vringe   | "AN L   | 2-11-1 X                                 |
| gove rise to immediate cause  |  | Jily of the   | - Som                                    |
| Toy, morning the orderying  |  |   |  |
| FART II. OTHER SIGNIFICANT CONDITION  | NS CONTRIBUTING TO DEATH BUT N   | T RELATED TO THE TERMINAL DISEASE COND                                  | ITION GIVEN IN PART 1(a) 19. WAS AUTOPSY |
| MO  | Added to the second sec |   | PERFORMED?                               |
| 20g. EXTERNAL CAUSE WAS 20b DE  | CRIRE HOW INJURY OCCUPPED 15   | or nature of injury in Port 1 or Port 11 of Item                        | YES NO                                   |
| CAUSE OF DEATH.   |  |   |  |
|   |  | OF INJURY (Home, form, 120f. (City or town, street, office bldg., etc.) | (County) (State)                         |
| B Hour a. m. 19   | While Not while tector of work of work   | , and the brings, and j   |  |
| 21. I certify that I took charge of I   | he remains described above   | , held on Autopsy . Inspect   | ion A toquiry 4 and in my                |
| opinion death resulted from: Natu   | rol causes 4. Accident   | , Suicide [], Homicide [],  | Undetermined manner                      |
| 7.5   | 11 ()"   |   |  |
| ACTUAL SIGNATURE  | 1300   | A.D. CHIEF MEDICAL EXAMINER   | DATE SIGNED                              |
|   |  | ASSISTANT MEDICAL EXAMINER  | 7/1/1/19                                 |
| EXAMINER'S Wlilam D. Bo   | yd M.D.  | DEPUTY MEDICAL EXAMINER   | - //3//5/                                |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify)                                 | 22c. NAME OF CEMETERY OR   | EMATORY 22d, LOCATION (C  | ity, lawn, or county) (State)            |
| Burisl 8/1/59   | Sacred Heart   | Bushwoo   | d, Maryland                              |
| 23. FUNERAL DIRECTOR'S SIGNATURE  | ADDRESS  | 100   | 246. REGISTRAR'S SIGNATURE               |
| W.Clarke Mattingley Leon  | ardtown, Maryland  | DATE AUG 4 '59  | Cuiting S. Knows                         |

TO DEPUTY MEDICAL EXAMINER. Fits certificate should be exacuted within 24 hours after death. If execute the reprificate, writing ford "pending" in pendi in them. 18. Give Pages 1, 2, and 3, 4 should it is warded to the Cr. of Medical Examiner's Office along with form PM3. Page 5 mag. TO FUNERAL RECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with at 18 designated agent, prior to burial, cremation, ar removal, and in any explicitly 72 hours of its designated agent. VS. ATSME 5M 2/57



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

director

Funerol

cample

and

physicion

ding

gned

9

CTOR

TO FUNERAL

15M 9/5B

ofter death Page



1.7

PHYSICIAN'S NAME (Type)

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 1 FilmG246 8-3-59 et CERTIFICATE OF DEATH

118342

8362 Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTS t. a. COUNTY a. STATE Maryts MARYLAND Marvland Marvis b. CITY OR TOWN (If autside corporate limits, write c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 RURAL and give nearest town) weeks St. George Island Avenue d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? Mrs. Poe's Care Home YES NO NO NAME OF Middle 4. DATE Day Month Yeor DECEASED Thomas (Type or print) Matthew Murphy DEATH 28 July 1959 6 COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 9. AGE (In years B. DATE OF BIRTH last birthday) 88 yrs Months Days Haurs Male White WIDOWED TO DIVORCED [ Jan.2.1871 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Railroad Engineer U.S.A. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Hattan Murphy Cenie Molesworth 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address No Albert Murphy None Avenue. Maryland 1B. CAUSE OF DEATH [Enter only one cause per line for (a), fb), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 PERFORMED? CAT YES IN NO I 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month. 20e PLACE OF INJURY (Home, farm, 20f. (City or town) Day. Year 20d INJURY OCCURRED (Stote) (County)

Hour o. m While Not while at work at work

factory, street, affice bidg, etc.)

, 19 5 That I last saw the deceased 21. I certify that I attended the deceased from alive on. , and that death occurred at \_M, fram the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED

**ACTUAL**SIGNATURE

22c. NAME OF CEMETERY OR CREMATORY

Grove

Mt. Airv

22d LOCATION (City, town, or county)

(State) Md.

Buria Pine" ADDRESS

22g. BURIAL, CREMATION, 22b. DATE THEREOF

(Specify)

24o, REC'D BY REGISTRAR DATE 1111 3 0 '59

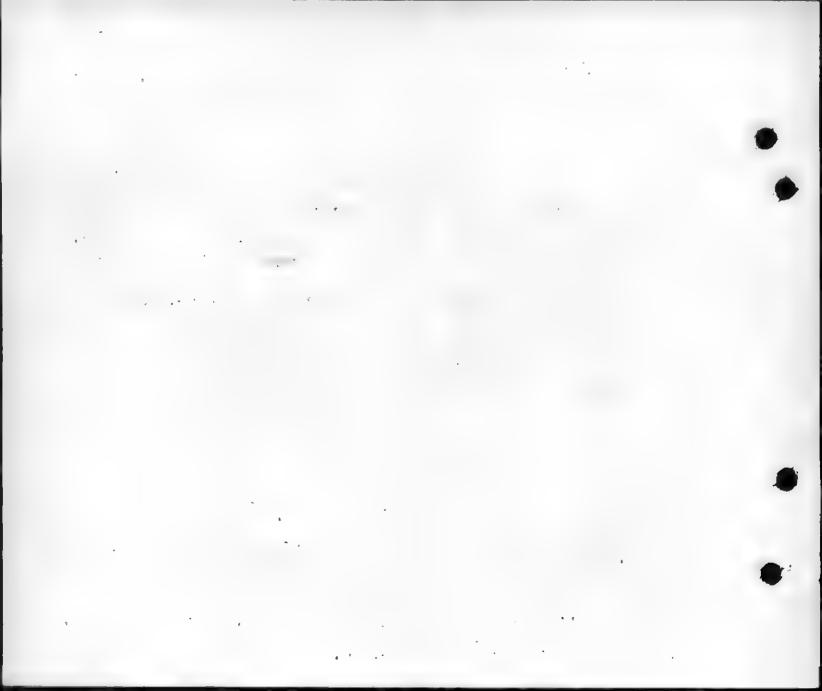
245 REGISTRAR'S SIGNATURE Orthon S. Kraus

Home Damascus. Md. Funeral

VS A15 (4) 15M 9/5B

may be r

0



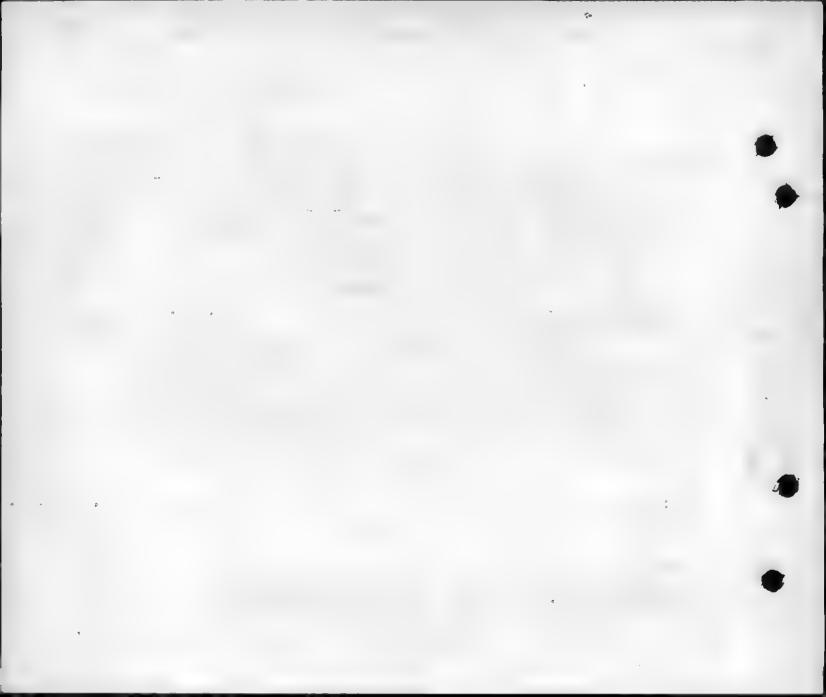
# FOR STATE HEALTH DEPT. y delay is necessory, please e funeral director. Page e retain for your files. he Sta TO DEPUTY MEDICAL EXAMINEPTO'S certifical should be execute the cartificate within 24 hours after death. If my delay is nexecute the cartificate, writing to ord "pending" in pendil in stem, 18. Give Pages 1, 2, and 3, et funeral 4 should a should the Continuation of the continuation of the cartificate of the cartificate states of the cartificate of the

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 8363

08343

|                            | 3000  |               |                                |           |  |                   |                                 | Reg. Dist     | l. No.                              |
|----------------------------|---|---------------|--------------------------------|-----------|--|-------------------|---------------------------------|---------------|-------------------------------------|
| 1. PLACE OF DEATH          |   |               |                                |           | . USUAL RESIDENC   | E (Where decea    | sed lived If institut           | ion: Resident | ce before admission)                |
| e. COUNTY                  | St. Marys   |               |                                | -         | o. STATE Mar   | ylanfi            | b. COUNTY                       | St            | . Marys                             |
| b. CITY OR TOWN II         | outude carparate limits, write                    | RURAL         | E. LENGTH OF STAY              | N 1b      | c. CITY OR TOWN  | V (If outside cor | porote limits, write            | RURAL and g   | give neoresf lown)                  |
|                            | on Park   |               |                                |           | X Lex  | rington           | Park                            |               |                                     |
|                            | AL OR INSTITUTION (IF                             | not in hospi  | lol, give street oddress       | )         | d STREET ADDRES  |                   |                                 |               | . IS HE. DENUI                      |
| F                          | Rural   |               |                                |           | R  | Rural             |                                 |               | YES NO                              |
| 3. NAME OF<br>DECEASED     | First   |               | Middle                         |           | Lost   | 4. DATE<br>OF     | Month                           |               | Doy Year                            |
| (Type or print)            | Jame  | S             | Yance                          | N         | eal  | DEATH             | 7 -                             | - 2           | 19 59                               |
| 5. SEX                     | 6. COLOR OR RACE                                  | 7. MARRIED    | NEVER MARRIED                  | ☐ B. D    | ATE OF BIRTH   |                   | 9. AGE (in years lost birthday) |               | YEAR IF UNDER 24 HR                 |
| male                       | colored   | WIDOWED       | DIVORCED [                     |           | <b>12-25-1</b> 8   | 373               | 85 yrs                          | Months D      | ays Hours Min.                      |
| 100 USUAL OCCUPATE         | ON (Give kind of work ding life, even if relired) | one 10b. Kil  | ND OF BUSINESS OR I            | NDUSTRY   | 11 BIRTHPLACE (S   | tate or foreign ( | ountry)                         | 12. CITIZE    | EN OF WHAT COUNTR                   |
| labo                       | orer  |               | farm                           |           | North  | 1 Carol           | ina                             |               | USA                                 |
| 13. FATHER'S NAME          |   |               | ne automotive i neu automotive | Ţī.       | 4. MOTHER'S MAIDE  | IN NAME           |                                 |               |                                     |
|                            | Alexander   | Neal          |                                |           | Unkr   | nown              |                                 |               |                                     |
| 15. WAS DECEASED EV        | ER IN U. S. ARMED FOR                             | CES? 16 50    | OCIAL SECURITY NO              | 17. INE   | DRMANT   |                   | Address                         | eu a empa     |                                     |
| [Yes, no. or unknown]      | (If yes, give war or dates of so                  | and a second  |                                | Wm        | R. Neal  | - Nagi            | ie. Va.                         |               |                                     |
|                            | TH [Enter only one caus                           | e per line fo | r (o), (b), and (c). )         | 1         | ALD VICOLT   |                   | 10g                             |               | INTERVAL BETWEEN<br>ONSET AND DEATH |
|                            | TH WAS CAUSED BY:                                 |               | Manain                         | bur       | nes M  | 4 C C 112         | =                               |               | immed.                              |
| 91600                      | IMMEDIATE CAUSE (a)                               |               | _ GRACIOTE                     | Ude       | 1100 _ / /   | 43 ) I V          |                                 |               | Zamou.                              |
| Conditions, if o           | DUE TO  |               |                                |           |  |                   |                                 |               |                                     |
| gove rise to imme          | diote couse                                       |               |                                | ·         |  |                   |                                 |               |                                     |
| (o), stating the           |   |               |                                |           |  |                   |                                 |               |                                     |
|                            | / (c)<br>HER SIGNIFICANT COND                     | ITIONS CON    | TRIBUTING TO DEATH             | BUT NO    | RELATED TO THE TE  | FRMINAL DISEAS    | E CONDITION GIVE                | N IN PART     | MAS AUTOPSY                         |
| PART II, OTI               |   |               |                                |           | The state of the s |                   | r constront on                  |               | PERFORMED?                          |
| 2 200 EVTERNAL CAL         | ISE WAS TON                                       | DESCRIBE      | HOW INJURY OCCUR               | PED /E-1- | a patrice of future.   | Mare Con Deat 1   | -f-a - 183                      |               | YES NO                              |
| PRIMARY DO CO              | NTRIBUTING -                                      |               |                                |           |  |                   |                                 |               |                                     |
|                            |   | resi          | dence com                      | DTE       | era des.   | rr.oyed           | oy 11re                         |               |                                     |
| 20c. TIME OF INJU          |   | MARIA         | Martin Co.                     | foctory   | street, office bldg ,  | elc.)             |                                 | (Count        |                                     |
|                            |   |               | of work                        | hon       |  |                   |                                 |               | st.Marys, M                         |
| 21. I certify it           | hat I taok charge                                 | of the re     | mains described                | abave     | , held an Auto   | opsy 🔲, I         | nspection 🔼,                    | Inquiry       | and in m                            |
| apinion death              | resulted fram: N                                  | latural co    | iuses 🔲. Accid                 | lent 🖾    | , Suicide []   | , Homicide        | . Undeter                       | mined mo      | anner 🔲                             |
|                            | 1   | 0             |                                |           |  |                   |                                 |               |                                     |
| SIGNATURE                  | /W/M  | 1/3           | -crsX                          | /         | AD. CHIEF MEDICA   | L EXAMINER [      |                                 | 7/0           | DATE SIGNED                         |
| EVALUATER/E                |   | _             |                                |           | ASSISTANT ME   | DICAL EXAMINE     | R 🔲                             | 1/2           | 2/59                                |
| EXAMINER'S<br>NAME (Type)  | Wm. D. Bo   | byd,          | MD                             |           | DEPUTY MEDIC   | CAL EXAMINER      | 2                               |               |                                     |
| 220. BURIAL, CREMATIC      | DN 225, DATE THEREO                               | 7             | 2c NAME OF CEMETE              | RY OR CR  | EMATORY  | 22d LOCA          | TION (City, town, o             | r county)     | (State)                             |
| REMOVAL (Specify<br>Burial | 7/6/59  |               | lst. Ba                        | pt.i.s    | st   | Le                | rington :                       | Park,         | Md.                                 |
| 23. FUNERAL DIRECTOR       | S SIGNATURE                                       |               | 1st Ba                         | In orac   |  | REC'D BY REGIST   | RAR 246. REGIS                  | TRAR'S SIGN   | ATURE                               |
| P.B. R                     | obinson -   | Leona         | ardtown.                       | Md.       | DATE   | JUL 1 4 '5        | 9 6                             | hur & 9       | tracel                              |



#### FOR STATE HEALTH DEPT

of director. Page for your files.

be retained the Sta y delay is

TO DEPUTY MEDICAL EXAMINEPTS: certificate should be executed within 24 hours after death. If ye execute the execute the execute the execute the execute the execute the executed for the Chief Medical Examiner's Office along with form PM3. Page 5 may be rectored to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retored to the Chief Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the or its designated agent, prior to burial, cremation, ar removal, and in any event within 72 hours after a

VS. A15ME 5M 2/57

8364

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08344

| *  |               | LACE OF DEATH                              |                                |               |                           |           | 2. USUAL RESIDE      | NCE (V    | Yhere deceor   | ed lived If     | institution. R      | esidence bef | ore adm ssion)  |
|----|---------------|--|--------------------------------|---------------|---------------------------|-----------|----------------------|-----------|----------------|-----------------|---------------------|--------------|-----------------|
|    | ٥             | S. COUNTY                                  | t. Marys                       |               | MARY                      | LAND      | O. STATE             | lar;      | vland          | 6 C             | OUNTY St            | . Mai        | rvs             |
|    | ь             | CITY OR TOWN [If a said give nearest lown] | uts de corporate limits, wi li | • PURAL       | c. LENGTH OF STAY         | IN 16     | c. CITY OR TO        | WN (If    | outside corp   | parate limits,  | write RURAL         | and give a   | earest town)    |
|    |               | and the second second                      | gton Parl                      | k. Md         |                           |           | Ties                 | rin.      | gton           | Park            |                     |              |                 |
|    | d             | NAME OF HOSPITA                            | OR INSTITUTION (               | If not in hos | pstal, give street addres | (a)       | J d. STREET ADD      |           | <b>6.226</b>   | . طفيطواط . داد |                     |              | e IS RES DEN. E |
| Χ. |               |  | Rural                          |               |                           |           | Rı                   | ma        | 1              |                 |                     |              | YES NO          |
| 1  | 3/ 1          | NAME OF<br>DECEASED                        | Fir                            | st t          | Middle                    |           | Lost                 |           | 4 DATE         |                 | Month               | Day          | Year            |
|    |               | Type or print)                             | Queen                          | ie            | Victoria                  | 1         | Neal                 |           | DEATH          | 7               | - 2-                |              | 19 59           |
|    | 5. \$         | £X   | 6 COLOR OR RACE                |               | D W NEVER MARRIED         | 8 0       |                      |           |                | 9 AGE ( n y     |                     | DER TYEAR    | IF UNDER 24 HRS |
|    |               | female                                     | colored                        | WIDOWED       | DIVORCED                  |           | 7-28-1               | L87       | 4              | ~ 4             | yes. Mont           | 11 Doys      | Hours Min       |
|    | 10o.          | USUAL OCCUPATION                           | N (Give kind at work           | done 10b K    | IND OF BUSINESS OR        | INDUSTRY  | 11. BIRTHPLACE       | (State    | ar fareign c   | ountry)         | 12.                 | CITIZEN O    | WHAT COUNTRY?   |
|    |               |  | ewife                          |               | omestic                   |           | Mary                 | z kai     | nđ             |                 |                     | USA          |                 |
|    | 13.           | FATHER'S NAME                              |                                |               |                           |           | 4 MOTHER'S MA        | IDEN N    | IAME           |                 |                     |              |                 |
|    |               | Ur   | ıknown                         |               |                           |           | XXXXXX               | XXX       | XXXX           | MMM             | XXXXX               | Unk          | mown            |
|    |               | WAS DECEASED EVE                           |                                |               | SOCIAL SECURITY NO        |           | ORMANT               |           |                |                 | ddress              |              |                 |
|    | 17.00         | no   |                                | agrance!      |                           | l W       | n. R. N              | eal       | _ Hs           | ague.           | Va.                 |              |                 |
|    |               |  | Enter only one cou             | se per line   | for (a), (b), and (c)     |           |                      |           |                |                 |                     | INTER        | VAL BETWENN     |
|    | l             |  | WAS CAUSED BY:                 | , Bi          | rnes ( Ma                 | aggi.     | ma )                 |           |                |                 |                     |              | mmed.           |
| -  |               | 911.0                                      | DUE TO                         | ,             | 44.11.                    | 700 T     | 7.40/                |           |                |                 |                     |              | Time Ca .       |
|    | П             | Conditions, il on                          |                                |               |                           |           |                      |           |                |                 |                     | -            |                 |
|    | Н             | gave rise to immedi                        | ole Couse                      |               |                           |           |                      |           |                |                 |                     |              |                 |
|    |               | (o), stoting the vi                        | (c)                            | )             |                           |           |                      | ,         |                |                 |                     |              |                 |
|    | 3             | PART II. OTHI                              | R SIGNIFICANT CON              | DITIONS CO    | NTRIBUTING TO DEATH       | H BUT NO  | T RELATED TO THE     | TERMI     | NAL DISEAS     | E CONDITIO      | N GIVEN IN          | PART I(o) 1  | P. WAS AUTOPSY  |
| 13 | CERTIFICATION |  |                                |               |                           |           |                      |           |                |                 |                     | 1            | PERFORMED?      |
|    | TIE           | 20g. EXTERNAL CAUS                         | E WAS 20                       | DESCRIBE      | HOW INJURY OCCUR          | RED (Ent  | or nature of injury  | in Part   | t I or Fort II | of item 18 }    |                     |              |                 |
|    |               | CAUSE OF DEATH.                            | KIBUING D                      | Res           | sidence co                | Famo      | etelv d              | est       | rive           | d by            | fire                |              |                 |
|    | 3             | 20c. TIME OF INJURY                        | Month, Day, Yes                | or 20d l      | NURY OCCURRED 20          | De. PLACE | OF INJURY (Hom       | e, farm   | , 120f (City   | or fown)        |                     | (County)     | (State)         |
| 0  |               | 3:15 -0.m                                  | 7/9/ 15                        | 9 of wa       | Not while                 | hom       | , street, office bid | ig., etc. | Lex            | ingto           | n Pari              | k.St.        | Marys, Md       |
|    |               |  |                                |               | emains described          |           |                      | utony     | -              | rspection       |                     | uiry K       |                 |
|    |               |  | esulted from:                  |               | -                         | dent 😾    | _                    |           |                |                 |                     |              |                 |
|    |               | opinion death i                            | esoned from:                   | 1 6           | doses [], Accid           | A)        | , soicide [          |           | Tomicide       | □, o,           | determine           | a monne      | . I             |
|    |               | ACTUAL                                     | 17.1                           | ' >           | +72.                      | V         | CHIEF MEDI           | CAL EX    | AMINER [       |                 |                     |              | DATE SIGNED     |
| ,  |               | SIGNATURE                                  | -AJZ                           | MA            | 1 solf                    | -         | MD                   |           | AL EXAMINE     | R 🗔             |                     | 7            | /2/59           |
|    |               | EXAMINER'S<br>NAME (Type)                  | Wm. D. Bo                      | . bvc         | MD                        |           |                      |           | EXAMINER [     |                 |                     | 11           | 2,09            |
|    | 220           | BURIAL CREMATION                           |                                | w             | 22c. NAME OF CEMETI       | ERY OR C  |                      |           |                |                 | own, or coun        | (v)          | (State)         |
|    |               | REMOVAL (Specify)                          | 7/6/59                         |               | 1st. Bap                  |           |                      |           |                |                 |                     |              | , ,             |
|    | 23            | FUNERAL DIRECTOR'S                         |                                | J             | ADDRESS                   | 7100      | 240                  | REC'I     | D BY REGIST    |                 | Park<br>REGISTRAR'S |              |                 |
|    |               | P.B. R                                     | obinson -                      | - Leo         | nardtown,                 | Md.       |                      |           |                |                 | ~                   |              |                 |



VS A15 (4) 1SM 9/5B

|  | ARYLAND \$1 | TATE DEPARTMENT | OF HEALTH—BALTIMORE, | 18 |
|--|-------------|-----------------|----------------------|----|
|--|-------------|-----------------|----------------------|----|

| 118 | 34 | 5 |
|-----|----|---|
|-----|----|---|

8365

M

#### **CERTIFICATE OF DEATH**

| -             |                                       |  |                  |                              |  |               |                |                                    |   |           |           |          |
|---------------|---------------------------------------|--|------------------|------------------------------|--|---------------|----------------|------------------------------------|---|-----------|-----------|----------|
| 1,            | PLACE OF DEATH<br>o. COUNTY           |  |                  | ***                          | II o. STATE                                  | DENCE (Wh     | ere deceased   | lived If institut<br>b. COUNTY     | on- Reside                              | nce befar | e admiss  | ion)     |
|               | Kerms                                 | St. Mary                                       | S                | MARYLAND                     | '  | Marvla        | and            |                                    | Mar                                     | nvls      |           |          |
|               | b. CITY OR TOWN (if RURAL and give no | f outside corporate Timi                       | ts, write        | c. LENGTH OF STAY IN 16      |  |               |                | ote limits, write R                |   |           | rest lown | )        |
|               | Leonardtov                            | m  |                  | 16                           | X Leon                                       | ardto         | וייי           |                                    |   |           |           |          |
|               | d. NAME OF HOSPIT                     | AL (If not in hospital, g                      | jive stree       | t address)                   | /d. STREET A                                 |               |                |                                    |   |           | e. IS RES |          |
|               | OR INSTITUTION                        | n Kome To                                      |                  | nd town Wa                   |  |               |                |                                    |   |           |           | FARM?    |
| 3             | NAME OF                               | r Kome -Le                                     |                  |                              |  |               | 4. DATE        | 14                                 | N.                                      |           | -         |          |
| 3.            | DECEASED                              | rir  | 21               | Middle                       | Los  | Т             | OF             | Mon                                | ith                                     | Day       |           | Year     |
| $\perp$       | (Type or print)                       | Mary   |                  | Frances                      | Owens  |               | DEATH          | July                               |   | 50,       |           | 1959     |
| S.            | SEX                                   | 6. COLOR OR RACE                               | 7- MAI           | RRIED NEVER MARRIED          | B. DATE OF BIRT                              | Н             | 9              | P. AGE (In years<br>lost birthday) | IF UNDE                                 |           | -         |          |
| Ь             | Female                                | White  | WIDOV            | VED DIVORCED                 | Feb.   | 23. 1/        | 893            | 66 yrs                             | Months                                  | Days      | Hours     | Min      |
|               | a. USUAL OCCUPATIO                    | N (Give kind of work                           | done 10b         | KIND OF BUSINESS OR INC      |  |               |                |                                    | 12 CI1                                  | TIZEN OF  | WHATC     | OUNTRY?  |
|               | during mast of work                   | ing life, even if retired                      | )                |                              |  |               |                | _                                  |   |           |           |          |
| 10            | House Wii                             |  |                  | Home                         | 1 110711551                                  | ****          |                | ryland                             |   | J.S.A     |           |          |
| 13            |                                       |  |                  |                              | 14. MOTHER'S                                 | WAIDEN N      | NAME           |                                    |   |           |           |          |
|               | John Phil:                            | ip Wilkinso                                    | n                |                              | Fran   | ces I         | ndiana         | Yates                              |   |           |           |          |
| 15            | . WAS DECEASED EVE                    |  | CES? 16          | SOCIAL SECURITY NO.          | INFORMANT                                    |               |                | Add                                | ress                                    |           |           |          |
| L"            | as, no, or waxnown,                   | In yea, give war or ourse or s                 | ervice)          |                              | Benjam                                       | in F.         | Owene          | 1.eo                               | nardi                                   | torm      | Ma        |          |
| F             | 10 CAUSE OF DEA                       | TM TE-t cally one on                           |                  | line far (a), (b), and (c).] | <u> </u>                                     | <u> </u>      | _016115        | пео                                | Har u                                   |           | RVAL BE   |          |
|               |                                       | TH WAS CAUSED BY:                              | lose per         | The lat (a), (b), and (c).   | +  |               |                |                                    |   |           | ET AND    |          |
|               | 1                                     | IMMEDIATE CAUSE (o                             | 1                | ancer of                     | Frings                                       | /             |                |                                    |   |           |           |          |
|               | 163X                                  | DUE TO   | +                |                              | 0  |               |                |                                    |   |           |           |          |
|               | Conditions, if a                      | ny, which ) (b                                 | 1                | 1                            |  |               |                |                                    |   |           |           |          |
|               | gove rise to it                       | mmediate Due to                                | *                |                              |  |               |                |                                    |   |           |           |          |
|               | lying couse last.                     | the <u>under-</u>                              |                  |                              |  |               |                |                                    |   |           |           |          |
| z             |                                       | IEP CIGNIFICANT CON                            | DITIONS          | CONTRIBUTING TO DEATH B      | LIT NOT PELATED TO                           | THETERMI      | NAL DISEASE    | CONDITION CIT                      | /EN IN PA                               | PT 1(a) 1 | WAS.      | ALITOPSY |
| [음            | 1200                                  | IER SOUTH TEATH COT                            | D1110143         | COLANGO LIAO TO DENTIL       | OT HOT KEDTED TO                             | /             | TALL DISEASE   | CO14D111O14 O11                    | r Did hat H                             | K1 1(0)   | PERFO     | RMED?    |
| _  5          |                                       |  |                  |                              |  |               |                |                                    |   |           | YES [     | NO 🗍     |
| CERTIFICATION | OR CONTRIBUTING                       | S UNDERLYING  CAUSE OF DEATH! MEDICAL EXAMINER | 20b. DE          | SCRIBE HOW INJURY OCCUR      | RED. (Enter noture o                         | f injury in I | Part   or Part | II of item 18.)                    |   |           |           |          |
| CALC          |                                       |  |                  |                              | B1 1 CF OF 15 14 1004                        |               | anc rec        |                                    |   |           |           |          |
| O.            | Hour a m.                             | Y Month, Day, Ye                               | or 20d,<br>While |                              | PLACE OF INJURY (<br>foctory, street, office |               |                | or town)                           |   | (County)  |           | (State)  |
| MED.          | p. m                                  | 19   | ot wo            | ork ot work                  |  |               | j              |                                    |   |           |           |          |
|               | 21. I certify th                      | at I attended the                              | decen            | sed from Isles               | 15 1950                                      | L to 2        | nen :          | 30, 195                            | and I I                                 | ast cau   | the d     | acanted  |
|               |                                       | ( 7 / ) ~                                      | 10               |                              |  | 1             | 5              |                                    |   |           |           |          |
|               | alive an_                             | <u></u>  | , 1½_            | , ghd that flea              | in accurred an                               | -             |                | he causes an                       |   | e date    |           |          |
|               | ACTUAL //                             | 1. 6.  | 10.              | 100-016                      |  | (0)           | WDD KE22 (210  | eet, city or town,                 | stole]                                  | 2.79      | BUAL      | E SIGNED |
|               | SIGNATURE E                           | aus M  | kk 1             | 100 cel                      | M.D  | V.S.J.        | rout           | lown                               |   | 66.4      |           |          |
|               | PHYSICIAN'S                           |  |                  |                              |  |               |                |                                    |   |           |           |          |
|               | NAME (Type)                           | Charles Gr                                     | eenv             | vell M. D.                   | Leo  | nardt         | own. Me        | aryland                            |   |           |           |          |
| 22            | BURIAL, CREMAT O                      | N 226. DATE THEREC                             | )F               | 22c. NAME OF CEMETERY        |  |               |                | ON (City, town,                    | ar county)                              | ,         | (Stat     | e)       |
|               | Buried (Specify)                      | 8-3-50   |                  | Our Lady's                   |  |               |                | ey Neck.                           | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Me        |           |          |
| 22            | FUNERAL DIRECTOR                      | SSIGNATURE                                     |                  | ADDRESS                      | VIIGPOI                                      | 24- 055       | D BY REGISTR   |                                    | STDA D'C C                              |           |           |          |
| 23            |                                       |  |                  |                              |  |               |                |                                    | SIKAKS S                                |           | t.        |          |
|               | W. Clarke                             | Mattingley                                     | 7                | Leonardtown,                 | Md.  | DATEUG        | 4 22           | - Care                             | The factor                              | r veauve  |           |          |



TO FUNERAL DIRECTOR: The faw requires that the death certificate be filled with the registrar within 72 hours after death. After certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of death certificate assembly should be defached for use as a burial transit permit.

A15C 1-55 10M ~

S

The bottom

this sich sich

Whin 24 hours after death.

#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

#### 8366 CERTIFICATE OF DEATH

05346

|  |                     |                                   |   | ry. Dist. No                            |        |
|--|---------------------|-----------------------------------|---|---|--------|
| 1. PLACE OF DEATH  |                     | 2. USUAL RESIDEN                  | CE (HOME) OF DE                               | CEASED                                  |        |
| COUNTY St. Marvs   | MARYLAND            | state Maryla                      | and county                                    | St. Marys                               |        |
| CITY (If outside corporete lymits, write RURAL   | ENGTH OF STAY       | CITY (If outside corpor           | rete fimits, write RURAL er                   | nd give neerest town)                   |        |
| OR end give neerest town) TOWN Callaway  | (in this place)     | OR TOWN (3-11-                    |   |   |        |
| HOSPITAL OR  |                     | X TOWN Calls                      | ilf rurel giv                                 | e location)                             |        |
| STREET ADDRESS Rural   |                     | ADDRESS Rura                      |   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |        |
| 3. NAME OF (First) (Midd   | dle)                | (Lest)                            | 4. DATE (Mon                                  | th) (Day) (Yes                          | br)    |
| (Type or Print) Charles Rol:   | and Pri             | 100                               | DEATH   | July 24 19                              | 59     |
| S. SEX   6. COLOR OR   7. SINGLE, MARRIED,   |                     |                                   | 7. AGE lest birthdey                          | IF UNDER 1 YEAR DIF UNDER               |        |
| RACE WIDOWED, DIVORC   | ED,                 |                                   |   | Months Deys Hours                       | Min.   |
| M W (Specificarrie)  10e. USUAL OCCUPATION (Give kind of work 10b. KIND O  |                     |                                   | 79 yrs.                                       | 40 61717711 05 1181                     |        |
| done during most of working life, even if OR IND   | USTRY               | 11. BIRTHPLACE (Stelle or foreig  | in connital                                   | 12. CITIZEN OF WH.                      | Aì     |
| retire Farming farm  | owner               | Maryland                          |   | USA                                     |        |
| 13. FATHER'S NAME  |                     | 14. MOTHER'S MAIDEN N             | IAME  |   |        |
| Joseph Price   |                     | Irene                             |   |   |        |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SC<br>(Yes, no, or unk.) (If Yes, give wer or detes of service) | DOTAL SECURITY NO.  | 17. INFORMANT & A                 | DDRESS  |   |        |
| no (11 tes, give wer or deles or service)  |                     | Martha M.                         | Price - C                                     | by would                                |        |
|  | 18. MEDICAL CER     | TIFICATION                        |   | INTERVAL BETY                           |        |
| 1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   | i 1                 | -11                               |   | ONSET AND D                             | EATH   |
| MMEDIATE CAUSE (A)   | 110001              | 16.8 trut                         | E 11 3  | 17/281                                  | 6. 1   |
| ANTECEDENT CAUSE(S) DUE TO   |                     | 1 7 -                             | / .   | ,                                       |        |
| DISEASES OR CONDITIONS, IF ANY, (B)  | 1 - 1 \ 321         | 10 15 15 15 15 15 1               | ( 2, 2 ) -                                    | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | 4      |
| STATING UNDERLYING CAUSE LAST, DUE TO  |                     |                                   |   | /                                       |        |
| (C)  |                     |                                   |   |   |        |
| TO THE DEATH BUT NOT RELATED TO THE  |                     |                                   |   |   |        |
| DISEASE OR CONDITION CAUSING DEATH.  |                     |                                   |   |   |        |
| 198. DATE OF OPERATION 196. MAJOR FINDINGS OF  | OPERATION           |                                   |   | YES NO                                  |        |
| 21e, ACCIDENT WAS UNDERLYING []   21b, PLACE (Home, fe   | rm. factory.        | 21c. WHERE DID INJURY OCCUR       | 2 (Cdy or town)                               | (County) (State                         |        |
| OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office (IF EITHER, NOTIFY MEDICAL EXAMINER)                     | bldg., etc.)        | ZIV. WILKE DID HOOK! O'CCON       | t (will lowing                                | (county) (Stee                          | 7.1    |
| 21d. TIME OF INJURY (Month) (Dey) (Yeer) (Hour) 21e. INJ   | URY OCCURRED        | 21f. HOW DID INJURY OCCUP         | 17  |   |        |
| M. et work   | et work             |                                   |   |   |        |
| 22. I hereby certify that I attended the deceased  | from this           | 1957 to 16                        | 1, 74 10 - 5                                  | that I last easy the de                 |        |
|  | ,                   | 1 11 1                            | 1   |   | cessed |
| alive on 19 19 19 19 19 19 19 19 19 19 19 19 19  | or death occurred a | M, from the c                     | auses and on the d<br>NESS (Street, city, tow |   | CHE    |
| With Jalmely   |                     |                                   | Tam ferroath entit (au)                       | n, stele) DATE SI                       | GRED   |
| 23. BURIAL CREMATION, DATE THEREOF   | M.D.                | Lexingt                           | On Park                                       | Md. 7/25/5                              | 9      |
| REMOVAL (SPECIFY)  |                     |                                   | 1   | i, or county)                           | Stetej |
| Burial 7/27/59   | Holy Fac            | e Cemetery 25. FUNERAL DIRECTOR'S | Gre   | at Mills, Md                            |        |
| 24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE   |                     | 25. FUNERAL DIRECTOR'S            | SIGNATURE                                     | ADDRESS                                 |        |
| JUL 28'59 Cirilar d. Frank   |                     | P.B. Robin                        | son - Leo                                     | nardtown. Md                            |        |



funeral director, suldibe filed with

may be retained by the haspital of Ending physician.

TO FUNERAL CORP. After this varificate has been signed by the attending physician and camp page 3 share corpored for use as the burial-transit permit. Then please remove carbon pages the registrar prior to burial, crematian, or removal, and in any event within 72 hours after death/

TO HOSPITAL OR

VS A15 (4) 15M 10/57

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| -[ | ) | 8 | 3 | 4 | 7 |
|----|---|---|---|---|---|
|----|---|---|---|---|---|

8367 **CERTIFICATE OF DEATH** 

| - 13 | Ò | 3 | 4 | 7 |
|------|---|---|---|---|
|------|---|---|---|---|

| 1. PLACE OF DEATH<br>a. COUNTY | St. Marv's                             | MARYLAND                        | II G. SIAIL ma                   | there deceased lived if institution b. COUNTY | Residence before admission)  St. Mary s |
|--------------------------------|--|---------------------------------|----------------------------------|---|---|
|                                | (If outside corporate limits, write    | c. LENGTH OF STAY IN 16         | c. CITY OR TOWN (IF              | outside corporate limits, write RUR           |   |
| A                              | ge Island                              | 18vrs                           | XSt. Georg                       |   |   |
|                                | ITAL (If not in hospital, give street  |                                 | d. STREET ADDRESS                |   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |
| 3. NAME OF<br>DECEASED         | First                                  | Middle                          | Last                             | 4. DATE Month                                 | Day Year                                |
| (Type or print)                | Robert                                 | L                               | Wagner                           | DEATH July                                    | 3, 1959                                 |
| 5. SEX                         | 6. COLOR OR RACE 7. MARR               | NEVER MARRIED                   | B DATE OF BIRTH                  |   | UNDER 1 YEAR IF UNDER 24 HRS.           |
| Male                           | White WIDOW                            | ED DIVORCED                     | June 16.188                      | 6 73 yrs                                      | Months Days Hours Min                   |
| 100 JSUAL OCCUPAT              | ION (Give kind of work done 10b.       | KIND OF BUSINESS OR INDU        | STRY 11. BIRTHPLACE (State       | ar foreign country)                           | 12. CITIZEN OF WHAT COUNTRY             |
| during most or wo              | rking life, even if retired)           |                                 |                                  | gton, D.C.                                    | U.S.A.                                  |
| 13. FATHER'S NAME              |  |                                 | 14. MOTHER'S MAIDEN              |   | U.D.A.                                  |
|                                | William W.                             | Mamon                           | Fathaning                        | Fligsboth Me                                  | at on                                   |
| 15. WAS DECEASED EV            | ER IN U. S. ARMED FORCES? 16.          | Wagner SOCIAL SECURITY NO. 17 B | NEORWANT THE                     | Elizabeth Ma                                  |   |
| (Yes. na. or unknown)          | (If yes, give war or dates of service) | 7-03-3684 M                     | arie A. Wag                      |   | ge Island, Md                           |
|                                | ATH [Enter only one couse per lin      | ne for (a), (b), and (c) ]      | 1 :                              |   | INTERVAL BETWEEN                        |
| PART 1, DE                     | ATH WAS CAUSED BY:                     | mary 0                          | Collesion                        |   | ONSET AND DEATH                         |
| 420.1                          | DUE TO                                 | V                               | 4 1                              |   |   |
| Candilians, if                 | any, which )                           | man at the                      | I deliver                        | 0   | le 40 m                                 |
| gave rise ta                   |  | 8                               |                                  |   | W pass                                  |
| fying cause last               | g the <u>under-</u>                    |                                 |                                  |   |   |
|                                | THER SIGNIFICANT CONDITIONS            | ONTRIBUTING TO DEATH BUT        | NOT RELATED TO THE TERM          | IINAL DISEASE CONDITION GIVEN                 | IN PART I(a) 19. WAS AUTOPSY            |
| E Cerain                       | non of lett-1                          | ens                             |                                  |   | PERFORMED?                              |
| 200. ACCIDENT W                | AS UNDERLYING   20b. DESC              | CRIBE HOW INJURY OCCURRE        | D. (Fater nature of injury in    | Part Lar Port II of item 18.1                 | YES NO 2                                |
| □ OR CONTRIBUTION              | G CAUSE OF DEATH Y MEDICAL EXAMINER    | CHIEF HOTH HOOK! OCCURRE        | o. (chief holder of injery in    | Total or roll in or neil 10.)                 |   |
| 3 20c. TIME OF INJU            |  | NJURY OCCURRED 20e. PL          | ACE OF INJURY (Home, for         | m. 20f (City or town)                         | (County) (State)                        |
| Y 20c. TIME OF INJU            |  | Not while for                   | ctary, street, office blog., etc | c.)   | ( //                                    |
|                                |  |                                 | 1                                | 14 / 7 10x                                    |   |
|                                | hat I attended the decease             | 77                              | 192 1, 10                        |   | that I last saw the decease             |
| alive an                       | 182                                    | , and that death                | accurred at 774                  |   | d on the date stoted above              |
| ACTUAL                         |  | MM 2                            | 0 - 0                            | ADDRESS (Signet, city or town, sle            | (a) BATE SIGNE                          |
| SIGNATURE                      |  | ff Den fl                       | 4                                | und frelle II                                 | 4 7/5759                                |
| PHYSICIAN'S<br>NAME (Type)     | P. J. Bean                             | м. р.                           | Grea                             | t Mills, Md.                                  |   |
| 220. BURIAL, CREMATI           |  | 22c. NAME OF CEMETERY O         |                                  | 22d. LOCATION (City, fawn, or o               | county) (State)                         |
| Burial ecity                   | 7/1/59                                 | Prospect                        | Hill                             | Washington,                                   | D.C.                                    |
| 23. FUNERAL DIRECTO            | R'S SIGNATURE                          | ADDRESS                         |                                  |   | AR'S SIGNATURE                          |
| W Olember                      | Madedana                               | Ma                              |                                  |   | us & Treated                            |



|   | 1   |      |
|---|---|------|
| FOR<br>HEALT  | STA   | ATE- |
| , Please<br>files.<br>Health,   |   | 1    |
| death. If any delay is necessary, pleas<br>2, and 2. De funeal director. Pag<br>Page 5 mone relatived for your files.<br>and 2 with the Stoil Ford of Health  | (   | 1    |
| delay is<br>funeral<br>retained   | death   | 7    |
| with the  | ors ofter   |      |
| is certificate should be executed within 24 hours after death. If any delay is ford "pending" in pencil in Item, 18. Give Pages 1, 2, and 1. Be funer Medical Examiner's Office along with farm PM3. Page 5 may be related to a buriot-transit permit. File pages 1 and 2 with the Stould be essed as a buriot-transit permit.  | in 72 ha  |      |
| Poges 1<br>P Poges 1<br>P PM3.  | ens with  |      |
| hin 24 h<br>3. Give<br>with fear<br>it. File  | n any ev  |      |
| flem It   | il, and i   |      |
| pencil in<br>s Office   | remove  |      |
| ing in<br>xaminer<br>as a be  | lien, or  |      |
| l "pendi<br>edical E  | I, cremo  | (    |
| NER Tais on a second as a should  | to buria  |      |
| EDICAL EXAMINER, This certificate should be executed within 24 hours after death. If any delay is necessary, please criticate, writing and "pending" in pending them, 18. Give Pages 1, 2, and 2 he functal director. Page remained to the Conf. Medical Examiner's Office along with farm PM3. Page 5 may be retained to your files. **RECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the Stol. Find of Health. | sted agent, prior to burial, cremation, or removal, and in any event within 72 haurs after deat |      |
| DICAL EXAMIN<br>prifficate, writing<br>prwgrded to the<br>RECTOR: Fogu  | uabo pa   |      |
| 0 5   | 100   |      |

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8368 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118348

| 131 | 1   | A APPLIA APPLICATION OF THE PROPERTY AND APPLICATION OF THE PR |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|-----|---|--|---|-----------------|-------------------------------------|--|--|-----------------------------|-----------------------------|--------------------------------|------------------------------|--|
|     |   | COUNTY   | St. Marys MARYLAND                        |                 |                                     |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  o. STATE Maryland b. COUNTY St. Marys |                             |                             |                                |                              |  |
| 1   | b   | Hollywo  | _   | ts, write RURAL | c. LENGTH OF STAY IN 16             | c. CITY OF   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town)  X Hollywood                                |                             |                             |                                |                              |  |
| 1   | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Rural |  |   |                 |                                     |  | d. STREET ADDRESS Rural  |                             |                             |                                |                              |  |
| 8   | 3, NAME OF<br>DECEASED<br>(Type or print)   |  |   | First           | Middle                              | Las  |  | DATE                        | Month                       | Doy                            | Year                         |  |
|     |   |  | John                                      |                 |                                     | eatley   |  | DEATH                       | July                        | 23                             | 1959                         |  |
|     | 5. 5  | EX   | 6. COLOR OR RACE 7. MARRIED NEVER MARRIED |                 | DATE OF BIRTH 9. AGE (In lost birth |  |  | GE (In years<br>t birthday) | Months Days                 | IF UNDER 24 HRS.<br>Hours Min. |                              |  |
|     |   | male   | white                                     | WIDOV           | WED DIVORCED D                      | /3/1907  | 7  |                             | 51 75.                      | Maritins Days                  | Hours Min.                   |  |
|     |   |  |   |                 |                                     |  |  |                             |                             |                                | F WHAT COUNTRY?              |  |
|     |   | Chauffer Trucking  |   |                 |                                     | Ma   | Maryland   |                             |                             |                                |                              |  |
|     | 13.   | 13. FATHER'S NAME  |   |                 |                                     |  | 14. MOTHER'S MAIDEN NAME   |                             |                             |                                |                              |  |
|     |   | J  | ohn Whe                                   |                 | Ann                                 | Annie L.Briscoe  |  |                             |                             |                                |                              |  |
|     |   | 75. WAS DECEASED EVER IN U. S. ARMED FORCES? 36. SOCIAL SECURITY NO. 17. INFORMANT Address   |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|     |   | no   |   |                 | 213-16-2034                         | Hanah 1  | 3. Whea  | atley                       | - Hol                       | lywood.                        | Md.                          |  |
|     |   | 18. CAUSE OF DEA   | TH [Enter only or                         | ne cause per li | ne for (a), (b), and (c).}          |  | 0  | . 1                         |                             | INTE                           | RYAL BETWEEN                 |  |
|     | PART I. DEATH WAS CAUSED BY: OLIVE Shot Wound of Lead. MILTON                       |  |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|     |   | 976 X DUE TO   |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|     |   | Conditions, if any, which) (b)   |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|     |   | gave rise to immediate cause (a), stating the underlying DUE TO  |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|     |   | couse lost, (c)  |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|     | 8   | PART II, OTH   | ER SIGNIFICANT                            | CONDITIONS      | CONTRIBUTING TO DEATH BUT           | NOT RELATED TO   | THE TERMINAL   | DISEASE CO                  | NDITION GIVE                | EN IN PART 1(0)                | 9. WAS AUTOPSY<br>PERFORMED? |  |
| )   | 3   |  |   |                 |                                     |  |  |                             |                             |                                | YES NO                       |  |
|     | CEPTIFICATION   | 20g. EXTERNAL CAU<br>PRIMARY ET OF COI<br>CAUSE OF DEATH.  | ISE WAS<br>NTRIBUTING []                  | 20b. DESCI      | RIBE HOW INJURY OCCURRED            | Enter noture of in   | jury in Pars 1 or  | Fort II of He               | m 18.)                      | 4.                             | -/                           |  |
|     | - 1   | 20c. TIME OF INJUI   |   | y, Year 20      | d. INJURY OCCURRED 20e. PL          | ACE OF INSURY (  | Home form 12   | Of City or to               | act of                      | (County)                       | (State)                      |  |
|     | MEDICAL   | Hour arm.  | 7-10                                      | W               | hile _ Not while _ fac              | tory, street, office   | bidg., etc.)   | 1/4                         | Cli w                       | 1 5/2                          | Zona notel                   |  |
|     | 2   |  |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|     | Н   | 21. I certify that ) took charge of the remains described above, held an Autopsy . Inspections, Inquiry , and in my opinion death resulted fram: Natural causes . Accident . Suicide . Hamicide . Undetermined manner  |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|     |   | opinion deam   | resurred from                             | 11/101010       | a causes []. Accident               | , Suicid   | e [P], Hon   | nicide [_]                  | , Underer                   | mined mann                     | er [_]                       |  |
|     |   | ACTUAL CHIEF MEDICAL EXAMINER (7) DATE SIGNED  |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|     |   | ASSISTANT MEDICAL EXAMINER 7/24/59   |   |                 |                                     |  |  |                             |                             |                                |                              |  |
| 2.  |   | EXAMINER'S WM . H. Patrick . MD A DEPUTY MEDICAL EXAMINER DE   |   |                 |                                     |  |  |                             |                             |                                |                              |  |
|     | 220.  | BURIAL, CREMATIO   | N, 22b. DATE TH                           | EREOF           | 27c. NAME OF CEMETERY O             | R CREMATORY  | 220  | I. LOCATION                 | (City, town, o              | r county)                      | (State)                      |  |
|     | Burial 7/25/59 Trinity  |  |   |                 |                                     |  |  | St. Marys City, Md.         |                             |                                |                              |  |
|     | 23.   | FUNERAL DIRECTOR   | 'S SIGNATURE                              |                 | ADDRESS                             |  | 24o. REC'D BY  | REGISTRAR                   | and the same of the same of | TRAR'S SIGNATU                 | RE                           |  |
|     |   | P.B. R   | obinson                                   | - Le            | onardtown, Mo                       | l.   | DATEJUL 2  | 8 '59                       | ant                         | hur S. Krau                    | <b>A</b>                     |  |
|     |   |  |   |                 |                                     | The second secon |  |                             |                             | The second second              |                              |  |

| 1. PLACE OF DEATH O. COUNTY  |                            | 2. USUAL RESIDENCE (Where deceased in           | ved. If Institution: Residen |   |  |  |  |  |
|--|----------------------------|---|------------------------------|---|--|--|--|--|
| St. Mary's   | MARYLAND                   | Maryland  |                              | Mary's                                  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   | c. LENGTH OF STAY IN 16    | c, CITY OR TOWN (If outside corporal            | e limits, write RURAL and s  | give nearest town}                      |  |  |  |  |
| Lexingtow Park   | 10 Yrs.                    | X Lexington Park                                |                              |   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp   | ital, give street address) | d. STREET ADDRESS                               |                              | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)  March Ve  | Middle Days                | Lost 4. DATE OF DEATH                           | Month 2                      | Doy Year                                |  |  |  |  |
| 5. SEX 6. COLOR OR RACE 7. MARRIEI   | D NEVER MARRIED . 8.       | DATE OF BIRTH 9. A                              | GE (In years   IF UNDER 1)   |   |  |  |  |  |
| Female Colored WIDOWED   | DIVORCED .                 | July 7, 1984                                    | OF yrs. Months D             | ays Hours Min.                          |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KI  |                            |   |                              | EN OF WHAT COUNTRY                      |  |  |  |  |
| House Work   |                            | Maryland  | U                            | S.A.                                    |  |  |  |  |
| 13. FATHER'S NAME  |                            | 14. MOTHER'S MATDEN NAME                        |                              |   |  |  |  |  |
| ???????????  |                            | Mary Adell Young                                |                              |   |  |  |  |  |
| 15. WAS DECEASED EVER IN.U. S. ARMED FORCES? 16. S<br>[Yes. no. or unknown] [If yes, give wor or dates of service]   |                            | FORMANT   | Address                      |   |  |  |  |  |
| ? ?  |                            | es Reed Ridge,                                  | Maryland                     |   |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for PART I, DEATH WAS CAUSED BY:   |                            |   |                              | ONSET AND DEATH                         |  |  |  |  |
| MMEDIATE CAUSE (6)   | ickle cell di              | sease   |                              |   |  |  |  |  |
| OLICIO DUE TO  |                            |   |                              |   |  |  |  |  |
| Conditions, if ony, which by gave rise to immediate cause  |                            |   |                              |   |  |  |  |  |
| (o), stoting the underlying DUE TO   |                            |   |                              |   |  |  |  |  |
| couse lost. (c)  |                            |   |                              |   |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONDIT | NIRIBUTING TO DEATH BUT NO | OT RELATED TO THE TERMINALDISEASE CO            | NOITION GIVEN IN PART        | YES NO                                  |  |  |  |  |
| 206. DESCRIBE PRIMARY Gr CONTRIBUTING CAUSE OF DEATH.  | HOW INJURY OCCURRED. (En   | ter nature of injury in Part I or Part II of it | em 18.}                      |   |  |  |  |  |
| 9  | JURY OCCURRED 200. PLACE   | E OF INJURY (Home, farm, 20f, (City or I        | own) (Caun                   | ly) (Stote)                             |  |  |  |  |
| Hour o, m. White of war  | k of work                  | y, street, office bldg., etc.)                  |                              |   |  |  |  |  |
| 21. I certify that I took charge of the re   | emoins described obov      | e, held on Autopsy , Inspi                      | ection , Inquiry             | , ond find that                         |  |  |  |  |
| deoth resulted from Notural causes   | , Accident , Suici         | ide 🔲, Hamicide 🔲, Unde                         | termined cause .             |   |  |  |  |  |
| ACTUAL ///// 1//   |                            | CHIEF MEDICAL EXAMINER                          |                              | DATE SIGNED                             |  |  |  |  |
| SIGNATURE A PER A CONTROL OF   | <del>\</del>               | M.D. ASSISTANT MEDICAL EXAMINER                 | 5 1                          | -                                       |  |  |  |  |
| EXAMINER'S<br>NAME (Type)  | 0                          | DEPUTY MEDICAL EXAMINER                         | 1-1                          | 2-57                                    |  |  |  |  |
| 220. BURIAL, CREMATION. 22b. DATE THEREOF REMOVAL (Specify)  | 22c. NAME OF CEMETERY OR C | REMATORY 22d. LOCATION                          | (City, town, or county)      | (State)                                 |  |  |  |  |
| Puria 7/11/59  | Holy Face                  | Great   | Mills                        | Md.                                     |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE   | ADDRESS                    | 24a, REC'D BY REGISTRAR                         | 24b. REGISTRAR'S SIGN        | 7.0                                     |  |  |  |  |
| W. Charke Mattingley, I  | Leonardtown                | Md. DATE JUL 1 6 '59                            | Cultur S.                    | Firmed                                  |  |  |  |  |

